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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

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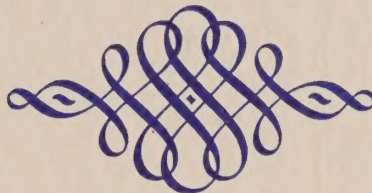
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held
in Ottawa, Ontario, on the 21st
day of March, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

Mr. M. WALLACE McCUTCHEON, Q.C.

Prof. O.J. FIRESTONE

Dr. DAVID M. BALTZAN

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

COMMISSION SECRETARY:

Mr. N. LAFRANCE

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I N D E X

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The Professional Institute of the Public Service of Canada	7234

E R R A T A

Volume # 22 - Edmonton
Page 4945, line 24.
For "Ontario" read "Alberta".



Ottawa, Ontario,
Wednesday, 21st
March, 1962.

---On resuming at 10:00 o'clock a.m.

THE CHAIRMAN: Yes, Mr. Hall?

MR. HALL: Mr. Chairman and members of the
Commission: the next submission is that of the
Royal College of Physicians and Surgeons of Canada
and I would ask that their brief be filed as Exhibit
No. 195.

---EXHIBIT NO. 195: Submission of Royal College
of Physicians and Surgeons of
Canada.

THE CHAIRMAN: Yes?

MR. HALL: And the French version is Exhibit
No. 195A.

---EXHIBIT NO. 195A: French version of submission
of Royal College of Physicians
and Surgeons of Canada.

MR. HALL: The summary and recommendations
contained in the brief will be presented by Dr. G.M.
Brown, the President of the College who will also
introduce the members of the delegation.

SUBMISSION OF ROYAL COLLEGE OF
PHYSICIANS AND SURGEONS

APPEARANCES:

Dr. G.M. Brown	Mr. T.J. Giles
Dr. L.G. Bell	Dr. G.A. Bergeron
Dr. R.M. Janes	Mr. R. Merriam
Dr. D.A. Thompson	
Dr. D.R. Webster	
Dr. J. Graham	

DR. BROWN: Mr. Chairman and members of the



1 Commission: It is my pleasure to introduce the
2 delegation. On my extreme left is Mr. T.J. Giles,
3 the Executive Secretary of the Royal College. Mr.
4 R.C. Merriam, Q.C., our legal counsel. Next to
5 him is Dr. G.A. Bergeron of Quebec City, Vice President
6 in medicine and the counsel of the College. Dr. D.A.
7 of Bathurst, New Brunswick who is the immediate Past
8 President of the College. On my right Dr. R.M. Janes
9 the Vice President of the College. Then there is
10 Dr. D.R. Webster, Professor of Surgery at McGill and
11 a member of the Executive of the Council. Dr. L.G.
12 Bell, Dean of Medicine, University of Manitoba and
13 the immediate past Vice President in medicine. At
14 the far end is Dr. J. Graham, Secretary of the
15 College.

16 105. The Royal College of Physicians and Surgeons
17 of Canada is a national voluntary body incorporated
18 by Act of Parliament of Canada in 1929. Prior to
19 that time no specialty qualification was available in
20 Canada and Canadian physicians and surgeons seeking
21 higher degrees found it necessary to turn for recognition
22 to the Royal Colleges of the United Kingdom or to the
23 American specialty bodies. Many physicians and
24 surgeons practised as specialists and consultants
25 without having sought formal recognition of their
26 competence from any source. The standard of specialty
27 practice was uneven, and identification of the
28 competent specialist not always easy. The Royal
29 College was incorporated for the purpose of providing
30 the means whereby the people of Canada might accurately



1 and readily recognize special training and competence
2 in the medical and surgical specialties.

3 106. The Royal College is an educational body
4 concerned primarily with the field of graduate medical
5 education and the development and maintenance of the
6 highest possible standards of qualification in the
7 medical and surgical specialties. It prescribes
8 the minimum requirements of graduate training,
9 approves hospitals and institutions which provide
10 satisfactory standards of training to meet these
11 requirements, and conducts examinations for the
12 qualification of specialists in more than twenty
13 clinical branches of medicine and surgery. The
14 examinations are conducted at two levels, that of the
15 Fellowship, the successful passing of which confers
16 the degree of Fellow and admission to membership in
17 the College, and that of Certification which is a less
18 searching examination in the broad fields of medicine
19 or of surgery but which is designed to ensure a high
20 standard of clinical competence in the specialty
21 concerned. The Fellowship degree of the Royal College,
22 obtained after passing a searching and comprehensive
23 examination, enjoys a high reputation both in Canada
24 and abroad.

25 107. The Royal College has not concerned itself
26 with such matters of medical economics as schedules
27 of fees.

28 108. There are now 2402 Fellows of the College,
29 959 physicians and 1443 surgeons. In addition 4813
30 other practising physicians and surgeons have been



1 certificated by the College. Since 1943 the number of
2 specialists available to the people of Canada has
3 increased by 250 per cent. These highly qualified
4 physicians and surgeons render a variety of important
5 services to our country. They provide a high standard
6 of diagnosis and treatment for those in need of
7 specialized care. They occupy key appointments in the
8 staff organization of hospitals where they contribute
9 in an important way to the continuous critical
10 evaluation of the quality of patient care. In the
11 university medical centres and in the approved teaching
12 hospitals they occupy positions of leadership in medical
13 education and contribute much of their time and effort
14 to both undergraduate and graduate teaching in the
15 clinical fields. Many are engaged in the direction
16 and conduct of clinical investigation or research and
17 in this way make a significant contribution to the
18 further development and advancement of scientific
19 medicine in Canada. That these highly trained and
20 competent specialists are available to the people of
21 Canada today is the result of a tremendous expansion
22 of facilities for graduate medical training since the
23 end of World War II. This has been brought about
24 by the combined efforts of the Royal College, the
25 Faculties of Medicine of Canadian universities and the
26 hospitals approved for graduate training. The
27 particular role of the Royal College has been the
28 establishment and maintenance of high standards. It
29 has carried out this role through its system of approval
30 of hospitals and institutions for graduate training, by



1 its regulations which set forth the minimum experience
2 required of each individual candidate and by the
3 conduct of examinations.

4 109. The provision of facilities is the
5 responsibility of the university medical schools and of
6 the teaching hospitals. There is now in Canada a
7 highly effective system of graduate medical education
8 which provides about 2400 residencies which meet the
9 requirements of the Royal College. Few candidates
10 now leave Canada for the whole of their graduate
11 education because of the improved and expanded facilities
12 available in Canada. Indeed an increasing number of
13 non-Canadian graduates are seeking specialty training
14 in Canada. The tremendous growth of graduate medical
15 training has created special problems for the teaching
16 hospitals and the university medical schools which
17 require attention.

18 110. The extensive graduate training programs
19 carried out in the university affiliated hospitals
20 involves considerable expense to the medical schools as
21 well as to the hospitals themselves. Well organized
22 training programs make systematic use of the basic
23 science facilities of the medical schools, and this
24 entails the considerable expense connected with all
25 graduate study. The universities provide a large part
26 of the personnel required to carry out and direct
27 research in the teaching hospitals, and in addition have
28 of course large programs of medical research within
29 their own departments. Leadership in the field of
30 graduate medical training has been given by our



1 universities, and they will require increasing
2 financial support with respect to this function if
3 they are to continue to make a contribution of the same
4 order as that which they have made during the past
5 twenty years.

6 111. The hospitals approved by the Royal College
7 for graduate medical training also have special
8 problems. About two-thirds of all hospitals approved
9 by the Royal College are affiliated with medical schools
10 and it is among these that as a rule one finds the
11 hospitals best equipped and staffed to conduct complete
12 programs of graduate training. It is these hospitals
13 which have facilities for education in the pre-clinical
14 sciences and opportunities for trainees to carry on
15 research and clinical investigation. In recognition
16 of the exceptionally high standard of education
17 available in these hospitals, the Royal College has
18 sought the closest cooperation of the medical schools
19 in expanding the number of university-sponsored programs
20 of graduate training in hospitals.

21 112. An essential part of graduate education in
22 the clinical specialties is graded responsibility for
23 patient care under expert supervision. This type of
24 training depends for its very existence upon the
25 availability of adequate numbers of patients on all the
26 teaching services. The Royal College shares the
27 concern expressed by medical educators about the supply
28 of patients who are willing to cooperate with the
29 hospitals and medical schools in their programs for
30 clinical training. The use of paying and insured



1 patients for teaching requires new approaches and
2 understanding by the medical profession and by the
3 public, and it requires the establishment of attractive
4 clinical units to which all classes of patients may be
5 admitted. Special problems arise in the training
6 of surgeons and these require study by those concerned
7 with surgical training and by those concerned with the
8 supply of surgical services throughout the country.

9 113. The junior internship represents the initial
10 phase of graduate training. It should be a well
11 organized educational experience during which the
12 intern becomes an integral part of the clinical team on
13 a teaching service and is given shared responsibility
14 for the care of patients. It is important that the
15 intern should receive adequate remuneration for his
16 valuable contribution to patient care.

17 114. It is important that all approved hospitals
18 engaged in graduate training in the various specialties
19 should have establishments for residents commensurate
20 with the training capacity of the various clinical
21 departments. The training capacity of a clinical
22 department is subject to assessment and approval by
23 the Royal College. Because of the important
24 contribution to patient care supplied by residents,
25 the remuneration of residents should be included in
26 the normal operating budgets of teaching hospitals, and
27 suitable increments should be provided as their training
28 advances. Since the presence of a clinical
29 investigation unit in a hospital raises the standard
30 of patient care in that hospital and contributes to the



1 training of the resident staff, the remuneration of
2 residents working on a clinical investigation unit
3 should be considered a part of the normal operating
4 cost of the hospital. Graduate students who are
5 preparing themselves to take the examinations of the
6 Royal College for Fellowship or Certification may
7 spend one or more years of study during which they are
8 not directly engaged in patient care or in research
9 and are, therefore, not eligible for financial support
10 in the usual ways. There is a need to fill this gap,
11 by training grants or training fellowships, so that
12 these graduate students may complete an appropriate
13 training without undue financial handicap. It
14 should also be the responsibility of a teaching
15 hospital to provide some remuneration to the heads of
16 the major clinical departments who assume large
17 administrative loads in addition to their responsibilities
18 in patient care, teaching and research.

19 115. The detailed tables in connection with that
20 part of this brief which deals with the present supply
21 and distribution of specialists in Canada show that
22 at September 30, 1961, there were 7,215 doctors who
23 held a specialist qualification from the Royal
24 College and who were engaged in active practice of
25 their specialty in Canada. The number represents
26 34.9 per cent of the estimated total number of doctors
27 in Canada. No authoritative or reliable indices are
28 known which would be applicable to the geographic
29 distances and distribution of population which prevail
30 in Canada, and which might serve to determine the



1 number of specialists required to meet adequately the
2 needs of the population for specialist care. Through
3 its own advisory committees in the various specialities,
4 the Royal College has attempted to assess the adequacy
5 of the existing supply of specialists in Canada. Based
6 on this assessment, it is our belief that shortages exist
7 in the following specialists: Anaesthesia, Bacteriology,
8 Dermatology, Ophthalmology, Otolaryngology, Obstetrics
9 and Gynaecology, Pathology, Paediatrics, Physical
10 Medicine and Rehabilitation, Psychiatry, Diagnostic
11 Radiology and Therapeutic Radiology. The extent of
12 these shortages varies between specialties and in
13 varying degrees between the various provinces and
14 between urban centres of different population size.
15 Shortages appear to be more acute in the Atlantic
16 provinces, and in general in urban centres of a pop-
17 ulation less than 25,000. Many of the national
18 specialty organizations will make submissions to the
19 Royal Commission and they will undoubtedly present
20 more detailed assessments of the adequacy of the
21 existing supply of specialists in their respective fields.

22 116. Because of its concern with the training of
23 specialists the Royal College is deeply interested in
24 the development of medical research in all its branches.
25 Good research means good teaching at all levels from the
26 basic science departments to the graduate clinical
27 departments. The provision of good research in a
28 hospital, as in a clinical investigation unit, raises the
29 standard of patient care in that hospital. The clinical
30 specialist who has done good research and continues to
do it remains abreast of his field. These are
all benefits of programs of medical research which



1 are important to the health care received by the
2 people of Canada, and they are of course all in addition
3 to the chief result of medical research, which is the
4 incre ase of medical knowledge. The health care of
5 the people of a country will not in the long run be
6 better than the provision which that country makes for
7 medical research. Some part of medical research is
8 so inextricably involved with the actual provision
9 of medical services that it cannot be separated from
10 it, and attempts to do so damage both the medical
11 services and the research. Other parts of medical
12 research are not so entwined with the procedures of
13 medical care, and should be separate from it both in
14 planning and in administration.

15 117. Medical research in Canada is a very
16 different thing now from what it was twenty years ago.
17 The Royal College is gratified by the part which its
18 Fellows have taken in the growth which has occurred.
19 It insists that men and women who attempt the
20 Fellowship examination should at least understand the
21 research method, and it encourages them actually to
22 engage in research as part of their training.

23 118. Canada, however, lags in its efforts in
24 medical research. More funds, more space and more
25 scientists are required if we are to do what is
26 necessary. A full research effort in proportion to our
27 resources is required if standards of health care in
28 Canada are to be what they should be. The Royal
29 College has noted with approval the recommendations
30 of the Farquharson Committee. It regards the



1 acceptance of the recommendation that an independent
2 Medical Research Council be established as an important
3 event. It believes the other recommendations should
4 be brought up to date and acted upon. Medical
5 schools and our teaching hospitals need the additional
6 facilities and support which the Farquharson Committee
7 sought for them. The provision of them would improve
8 the health care of the people of Canada.

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RECOMMENDATIONS

119. The Royal College of Physicians and Surgeons of Canada recommends to the Royal Commission on Health Services:

i) that its authority as an independent national voluntary body which provides standards for the training and recognition of medical and surgical specialists in Canada be preserved in any future plan of health services for Canada;

ii) that in any plan providing for the health care of the people of Canada, the present minimum standards of specialty qualifications as laid down by the Royal College be maintained, subject to such changes and improvements as are indicated from time to time by advances in medical science and in the prevention, diagnosis and treatment of disease;

iii) that the facilities which now exist in hospitals across Canada for graduate education in the medical and surgical specialties be gradually expanded to meet the increased needs of the people of Canada for specialist care, and in particular

a) that in any new plan for the health care of the people of Canada which may arise from the studies of the Royal Commission on Health Services provision be made to ensure the availability of an adequate number of patients for the training of internes and residents in hospitals which are engaged in graduate training in the clinical specialties;



- 1 b) that approved hospitals be provided
2 the means to establish attractive clinical
3 teaching units for the care of all
4 classes of patients who wish to be
5 treated in such units;
6 c) that adequate funds be provided for
7 facilities for clinical investigation;
8 d) that adequate funds be provided for
9 the maintenance of active out-patient
10 departments;
11 e) that the heads of clinical departments,
12 who, in addition to their activities in
13 patient care, teaching and research,
14 undertake heavy administrative responsibilities,
15 be remunerated for these
16 services;
17 f) that the establishment of resident
18 staff in a teaching hospital be that
19 recommended by the heads of the clinical
20 departments within the limits of the
21 approval for training granted by the
22 Royal College.
23 g) that adequate remuneration be paid
24 the resident staff with increments as
25 their training advances in recognition
26 of the increasingly valuable contribution
27 which they make to patient care;
28 h) that adequate remuneration be paid
29 the resident staff engaged in clinical
30 investigation during their training



1 program;

2 iv) that the Faculties of Medicine, whose
3 budgets have hitherto been intended primarily to meet
4 the cost of undergraduate medical education, be given
5 financial assistance to enable them to meet the cost of
6 organizing and operating graduate training programs and
7 programs of continuing graduate training, and in parti-
8 cular

9 a) that it be made possible for them to
10 engage the additional teaching staff
11 required for both clinical and pre-clini-
12 cal departments;

13 b) that there be financial recognition
14 of the contribution which members of
15 the Faculties of Medicine make to pro-
16 grams of clinical investigation;

17 c) that training grants or fellowships
18 be provided for those who undertake
19 graduate training relevant to the clini-
20 cal specialties but who are not actively
21 engaged in service to patients or
22 pursuing research under a fellowship or
23 research grant;

24 d) that provision be made for the univer-
25 sity medical schools to expand their
26 physical plants so that they may ade-
27 quately discharge their responsibilities
28 in the training of medical and surgical
29 specialists;

30 v) that in the design of any new plan for



1 health care in Canada the fullest recognition be given to
2 the essential place of medical research as the basis for
3 advance in all types of health care, and that the recommen-
4 dations of the Farquharson Report concerning the establish-
5 ment of additional facilities and greater support for
6 medical research in the Faculties of Medicine and the
7 training hospitals be accepted and expanded.

8 THE CHAIRMAN: Thank you very much Dr.
9 Brown. I would like to extend the thanks of the Commis-
10 sion to the Royal College for this presentation and the
11 submission which is now before us. You have given us in
12 very concrete form much of the data and information that
13 we would naturally be looking for and to that extent
14 that the information is here we necessarily do not have
15 to probe for it as we may have had to do in other
16 instances, but there are a number of points upon which
17 I think members of the Commission will ask for the
18 opinion of the College and perhaps some clarification
19 and also some questions perhaps dealing with the compari-
20 son of the situation in Canada with other countries;
21 conscious, as you say, at the top of page 34, that the
22 Royal College has not concerned itself with such matters
23 of medical economics as schedule of fees and that kind
24 of thing, so that our discussion here this morning may
25 take a little different line than perhaps with the
26 Medical Associations and those associations which are
27 more primarily concerned with medical organizations and
28 medical economics.

29 Dr. Van Wart, have you something you
30 wish to discuss?



1 COMMISSIONER VAN WART: Yes. I notice
2 on page 36, the bottom line, speaking about percentage
3 of specialists to the number of doctors in Canada; you
4 mention that 34.9% of the doctors in Canada are specia-
5 lists and you go on to say later, on page 37, that there
6 are shortages in certain branches.

7 Does the College, as a policy, endeavour
8 to influence students to fill these shortages? These
9 specialties where there are shortages?

10 THE CHAIRMAN: Dr. Brown, you may if
11 you wish just remain seated for this more or less informal
12 discussion that now goes on.

13 DR. BROWN: Mr. Chairman, Commissioner,
14 the answer to the question is no. We do not. Our job
15 is to set the standards for entry into the specialty,
16 not to regulate the number going into the specialties.

17 THE CHAIRMAN: Not even indirectly if
18 one specialty shows the inclination of being overcrowded
19 and others are deficient that there is no guidance in
20 that way?

21 DR. BROWN: Not as a function of the
22 College, sir. The means of entry to the College is
23 through examination.

24 THE CHAIRMAN: That is from the medical
25 school.

26 DR. BROWN: And the level of the examina-
27 tion, of course, cannot be influenced by the views of
28 anyone concerning the adequacy of the number of specia-
29 lists in that particular subject.

30 COMMISSIONER VAN WART: You do not make



1 available to the profession the information that there
2 are shortages in certain specialties?

3 DR. BROWN: That is to say have our
4 views expressed here about the shortages been published?

5 COMMISSIONER VAN WART: Yes.

6 DR. BROWN: No, they haven't. The
7 assessments made by our Specialty Committees were made
8 very recently and there has been no publication given
9 to them until today.

10 COMMISSIONER VAN WART: As a College,
11 do you feel that certain specialties are overcrowded?

12 DR. BROWN: No, we do not. We do not
13 think there is overcrowding in any of the specialties
14 at the moment.

15 THE CHAIRMAN: Is that on the national
16 level? Speaking on a national level, but can you say
17 the same thing about certain areas in Canada? Certain
18 cities and that kind of thing because we have heard
19 suggestions to the contrary.

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1 DR. BROWN: That is a very large ques-
2 tion, to say that there is no crowding in any particular
3 area. I would like to ask Mr. Giles, who is responsible
4 for the particular details, information provided about
5 the distribution of specialists, if he has comments
6 that come out of the work he did on it.

7 THE CHAIRMAN: Mr. Giles?

8 MR. GILES: Mr. Chairman, we haven't
9 attempted to make a detailed analysis of the supply in
10 individual centres. We have simply presented the factual
11 information as to what the supply is. The major problem
12 is to know what indices you can supply by determining
13 what your needs may be, and these are not available, as
14 is pointed out in the brief.

15 COMMISSIONER VAN WART: You have, in
16 your membership, a number of fellows who wrote their
17 examinations outside of Canada?

18 DR. BROWN: Yes, we have indeed, who
19 have taken the greater part of their training outside of
20 Canada. They are not graduates of our medical schools.

21 COMMISSIONER VAN WART: Those who are
22 fellows, graduates of Canadian medical schools, do many
23 of them leave Canada and go to other countries?

24 DR. BROWN: The number is becoming
25 smaller as time goes on, and is not now very large. We
26 have a table in the body of the brief which sets out
27 those that are outside of Canada.

28 COMMISSIONER VAN WART: Does the College
29 make an effort to register the number where their various
30 members or fellows reside at different times?



1 DR. BROWN: Yes, indeed, sir. We have
2 attempted to keep the record on that up to date, as
3 accurate as we can make it in that respect.

4 DR. GRAHAM: There is a geographic list
5 of those residing outside of Canada on pages 172 to 177.

6 COMMISSIONER VAN WART: Yesterday, as
7 many of you know, CAMSI appeared before us and they made
8 the statement that training in medical schools is more
9 for the training of specialists rather than general
10 practitioners. Do you have any comment on that?

11 DR. BROWN: In a sense this is outside
12 the real sphere of interest of the College, which is in
13 graduate training. I would say that the group that were
14 here yesterday were largely from one medical school,
15 weren't they?

16 But I would suspect the views they
17 expressed were a slight disappointment to their instruc-
18 tors in that their instructors across the country are
19 attempting to provide the student with a course prepara-
20 tion which is as good for general practice as it is in
21 this country.

22 COMMISSIONER VAN WART: Thank you, Mr.
23 Chairman. The brief covers the rest of the questions I
24 had in mind.

25 THE CHAIRMAN: Just covering the point
26 on the last question of Dr. Van Wart, the students yester-
27 day did purport to say that while in the nature of their
28 organization the Executive came from the host school
29 each year and therefore it is only accidental in that
30 sense they came from Dalhousie in 1962, they had visited



1 nine schools and purported to speak for the students of
2 nine schools and that they are not aiming this at their
3 own schools.

4 Now, is it possible that there may be
5 some germ of truth in the suggestion that with so much
6 emphasis on the specialties the courses orient very
7 early towards the specialties and to that extent may
8 inhibit the training of the general practitioner, because,
9 after all, we are still going to need two general practi-
10 tioners for each specialty?

11 DR. BROWN: Mr. Chairman, there are
12 quite a few of the people present that have dealt with
13 that problem, and I would like to ask Dean Bell, who has
14 spent a long time on this problem, to answer the question.

15 DR. BELL: The four years, the regular
16 curriculum, must cover a lot of territory. The student,
17 it is true, is exposed to specialists who are also
18 teachers, and during his course he is exposed to the
19 type of patient care he would need in any type of prac-
20 tice and particularly in general practice.

21 In other words, he is introduced to the
22 patient on that side; he is then introduced to interviewing
23 patients in the out-patient department and in many schools
24 in the home care type of service. So his training in the
25 Department of Medicine - this happens to be my particular
26 interest - we think contains a great deal of this sort of
27 interest.

28 He must learn in order to become what
29 we call a basic doctor or graduate; he must learn the
30 basics of medicine, surgery, including the basic sciences,



1 otherwise he wouldn't be a doctor, and we feel that he
2 begins to develop, and during his internship.

3 THE CHAIRMAN: I don't know if you were
4 present during the hearing in Winnipeg, Dr. Bell?

5 DR. BELL: No, I wasn't there, sir.

6 THE CHAIRMAN: The College there, purpor-
7 ting to be speaking on behalf of some of the general
8 practitioners in Manitoba, made this complaint very
9 forcibly, that the general practitioner was being sort
10 of forgotten, the forgotten man in medical education,
11 and so that in addition to the complaints that we have
12 had the general practitioners here and there say the
13 same thing.

14 COMMISSIONER VAN WART: I might say
15 these people did not belong to the College of General
16 Practice.

17 DR. BELL: I might say that we have the
18 greatest sympathy for the general practitioner and their
19 problems, but our job is to produce the undifferentiated,
20 well-trained young man as a graduate without any bias in
21 any direction.

22 I think that the good student who makes
23 up his own mind can, and certainly there is no influence
24 brought to bear.

25 THE CHAIRMAN: Now, moving to another
26 subject altogether, it has been urged upon this Commission
27 by various bodies who have made submissions that this
28 Commission should ultimately recommend some form of
29 national plan.

30 Now, there have been various plans



1 suggested, and some say, "Well, we should have the kind
2 of plan that there is in England or in Australia or
3 Sweden, Norway, these various places". On the assumption
4 that a national plan would be inaugurated in Canada, has
5 the College any views to offer on the future of specialist
6 training, on the assumption that there was some form of
7 national plan now, whether it was complete State medicine
8 as you have in England or as it is in other countries?

9 DR. BROWN: Yes, we have, sir, and our
10 submission is that the standards for entry into specialist
11 practice are those set by the Royal College, no matter
12 what the scheme. We think there is merit in having this
13 done by an independent body, a body which is not related
14 organizationally except in criss-cross membership to the
15 national bodies, a body which is not related directly to
16 universities or to teaching hospitals, and a body which
17 is not related directly to government; it has a quality
18 of independence which we think is valuable.

19 Without making the slightest comment on
20 the merit of the scheme in force in the U.K., one might
21 point out that even there the function of the Royal
22 College is left as it was there before the National
23 Health Scheme came into force.

24 THE CHAIRMAN: That is your recommendation
25 on page 39.

26 DR. BROWN: Yes.

27 THE CHAIRMAN: I was wondering, in the
28 position in which you place it, whether you have any
29 fears, any apprehension that the status of the Royal
30 College would be affected arising from anything that



1 ever happened elsewhere?

2 DR. BROWN: Well, of course, it is a
3 possibility that occurred to us, and ---

4 THE CHAIRMAN: I mean, has that been
5 the result anywhere else, in the United Kingdom, Australia
6 or anywhere else?

2 7 DR. BROWN: Not insofar as I am aware,
8 but others may know more of it. We would hope that the
9 job that has been accomplished by the College in the
10 last five years, which we think has been a good one,
11 would be a strong argument against any possibility of
12 change.

13 THE CHAIRMAN: That is the function of
14 the College?

15 DR. BROWN: Yes, that is right.

16 THE CHAIRMAN: Coming to another aspect
17 of it, the training of the specialist, can that be
18 affected, do you see that as being affected by the adop-
19 tion of an overall plan of some kind?

20 DR. BROWN: Yes, it may well be, because
21 the training of the specialist is influenced by many
22 features of the institution in which he trains and by
23 the money which is paid him to live while he is training,
24 and we have set out some of these points which we think
25 need attention now, as well as in the future, features
26 which, if given adequate attention, would improve the
27 training of the individual specialist in this country.

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1 THE CHAIRMAN: Bringing it back to Canada,
2 has the present hospital plan had any effect on the
3 training of specialists, because you mention on page
4 39, paragraph 3A that, and I am not talking about only
5 bad effects, either way, good effects or bad, because
6 you say that in any new plan for the health care of
7 the people of Canada provision be made to ensure the
8 availability of an adequate number of patients for
9 the training of interns and residents. Now, there
10 must be some thinking behind this recommendation.
11 What is it?

12 DR. JANES: Well sir, I think that behind
13 this is the fear that should every patient be covered
14 by any scheme, our facilities, our great teaching
15 areas in these teaching hospitals might disappear.
16 At the present moment the essential thing is that
17 every patient who is admitted to such an area is
18 available for teaching, and that they come under
19 the direct control, in the first place of the Chief
20 of Services in medicine or surgery and what not,
21 and only those who are members of the hospital and
22 university staff are privileged to care for them.
23 They provide a unit upon which a complete training
24 may be carried out, from undergraduate to the various
25 stages of post graduate training, with an increase
26 in degree of responsibility, which is an essential
27 part of the training, and I think it is that to which
28 this refers.

29 DR. BROWN: Yes it is.

30 THE CHAIRMAN: Accepting that, what has



1 happened with the present hospitalization plan, which
2 makes every patient a paying patient. We have no
3 more non-paying patients in that sense.

4 DR. BROWN: May I break that down a little
5 bit?

6 THE CHAIRMAN: Please.

7 DR. BROWN: Almost every patient is a paying
8 patient with respect to his hospital bill. There
9 remains the problem of whether he pays his medical
10 fees or not.

11 THE CHAIRMAN: I am only talking now about
12 the effect of the hospitalization plan which is now
13 in operation in Canada, under which everybody is
14 supposed to be covered for hospitalization. Now, has
15 that affected the availability of an adequate number
16 of patients for the training of interns and residents?

17 DR. BROWN: Yes, it has because it has
18 tended to reduce the number of patients in what we
19 used to call the public wards, which were the
20 foundation on which most teaching units were built,
21 and it has increased the number who have sought
22 to have their hospital care provided in private and
23 semi-private accommodation within the hospital, and
24 therefore as a rule they are very often outside
25 the teaching units.

26 THE CHAIRMAN: Dr. Bergeron, your experience
27 has not been as long in the province of Quebec. What
28 has been the experience?

29 DR. BERGERON: L'établissement de l'Assurance-
30 hospitalisation dans la Province de Québec a certes



entraîné des perturbations considérables dans la disponibilité des patients aux fins de l'enseignement clinique, mais il faut reconnaître que cette transformation avait été prévue et même qu'elle fut progressivement introduite par le nombre toujours croissant des malades pourvus d'une assurance-santé privée, réduisant d'autant les malades qui fréquentaient des services dits "publics".

THE CHAIRMAN: Y a-t-il encore des indigents dans la province de Québec?

DR. BERGERON: Non, au sens legal du terme, en ce qui concerne l'hospitalisation.

Pour obvier à cette situation, nous avons dû utiliser de plus en plus des patients assurés simplement, semi-privés ou privés qui consentent à être traités par une équipe formée du professeur et de ses assistants à divers stages de leur formation. Cette équipe leur assure des soins de haute qualité et l'assurance d'une attention constante de tous les membres de l'équipe qui assument une responsabilité graduée selon leur avancement.

Cette responsabilité progressive est un élément essentiel à la formation du résident. Pour devenir un spécialiste compétent, il importe que le résident puisse pouvoir indépendamment poser un diagnostic, établir une thérapeutique et éventuellement pratiquer les actes professionnels nécessaires.

Ces unités d'enseignement peuvent entraîner un conflit avec la liberté du patient de choisir son médecin, mais le patient peut librement consentir à



1 être traité par une telle équipe, sous la direction
2 et la responsabilité du professeur, conscient d'y
3 trouver des soins de première qualité et en même temps
4 de contribuer à un programme d'enseignement spécialisé.

5 THE CHAIRMAN: Has there been any evidence
6 accumulated that in the provinces where the plan has
7 been in operation for five, six or as much as ten years,
8 or more, that there is a reluctance on the part of
9 those covered by hospitalization to permit themselves
10 to participate in a training program?

11 DR. BROWN: There has of course been a
12 reluctance on the part of some people. This is
13 diminishing. It has required education, not only
14 of the patients, but of the profession itself, to
15 bring this about. It has required, too, education of
16 hospital staff, from the lowest member up almost, so
17 that they might change some of their old, traditional
18 attitudes. The problem is getting smaller, but it
19 is still sizeable and as we point out in the brief,
20 one of the obstacles in our way now is the fact that
21 many of the teaching units that previously housed public
22 wards are some of them obsolescent, many of them stand
23 in comparison with private wards very badly and on
24 this side of things there is need for a good deal
25 of attention, so that the teaching patient is a
26 patient who wants to enter a teaching unit, and not
27 a patient who must enter a teaching unit for economic
28 reasons. So this must be brought about, and he
29 must get the same attention, both with respect to the
30 cupboard he hangs his clothes in and the medical care



1 he gets. All these things must be evened out if we
2 are to get the type of teaching and training we want.

3 THE CHAIRMAN: Dr. Macleod, I see you are
4 present and I don't wish to embarrass you, but would
5 you care to give us any views from the experience of
6 the hospital in Saskatoon?

7 DR. MACLEOD: Yes sir, that is true, and
8 I think it started off in that hospital in January,
9 1955 with the understanding that any who entered would
10 participate willingly in the teaching program. This
11 appealed to patients. I think the patients found
12 they learned more about themselves as a result of this.
13 Sometimes a patient would complain that he was not
14 having a clinic at his bedside and his neighbour had
15 had this, and he wanted the same benefits. I think
16 in this respect that the biggest limitation is in the
17 attitude of the doctor. If the doctor wishes to
18 bring his patient into a teaching setting, he can do
19 that very readily. The patient knows that the teaching
20 atmosphere is good from the standpoint of his own
21 care.

22 COMMISSIONER VAN WART: Mr. Chairman, is it
23 a fair statement that the reluctance is not to the
24 teaching examinations by residents, by residents and
25 interns, but it is to the undergraduate student?

26 DR. BROWN: Well sir, I have been surprised at
27 what I have seen happen in this respect. There is
28 not the disparity in this that one might think in
29 advance, and if the student conducts himself properly,
30 and it should be part of his training that he learn



1 how to do this properly, then there is no objection
2 to it on the part of the patient, except in one
3 situation which I might mention, and that is the
4 situation in which we overload our patients with
5 teaching, and this has to be watched, and of course
6 should be watched with any type of patient, and here
7 of course there is legitimate grounds for objection.
8 If the teaching of students has to be done on too
9 small a group of patients, there is danger that it
10 becomes burdensome.

11 THE CHAIRMAN: Dealing with the intern, and
12 the resident, and the heads of the major clinical
13 departments, you have made a recommendation that they
14 all should be rolled into one, that there should be
15 proper compensation and that it should be part of
16 the operating costs of the hospital. Is there
17 actually any impediment now, I mean any legal
18 impediment to that being done, so far as you know,
19 in the hospitalization scheme?

20 DR. BROWN: In the actuality, sir, we find
21 some difficulty in accomplishing some of these things.

22 THE CHAIRMAN: It is a matter of getting the
23 budget up I suppose?

24 DR. BROWN: And it is reported to us that
25 there is objection taken to some of these items by
26 the hospital commissions, that they are not legitimate
27 items for budgets of a hospital. We would like to
28 make the point that the teaching hospital is entirely
29 necessary to our country, and has special expenses
30 which other hospitals do not have, and these should



1 be recognized, and they should be met.

2 THE CHAIRMAN: It is a matter, is it not, of
3 overcoming the historical development of the specialist
4 in the teaching hospital devoting so much of his
5 time, really gratis to the hospital?

6 DR. BROWN: The payment of the teachers is
7 only part of it. The adequate payment of resident
8 staff and the provision for the facilities of teaching
9 resident staff, and so on, these are also parts of
10 it. It certainly has its origin historically in the
11 pattern of medical practice.

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1 Some of us fear that too much history may pass before
2 it is completely solved. At the present rate these
3 problems have been with us for many years in some of
4 the provinces and they are still requiring solution.

5 COMMISSIONER McCUTCHEON: Is not part of
6 the problem an attempt on the part of the Hospital
7 Commission to distinguish between that budget which
8 is pure maintenance and that part which may be directed
9 to medical research?

10 DR. BROWN: Exactly, and one of the points
11 we would like to make is this, that in the hospital
12 the presence of good teaching and the presence of
13 research is a very good contribution to the care of
14 the patients in the hospital and not something
15 ancillary. It is not something which is free loading.
16 It is something which is making an important
17 contribution to the treatment of the patient in the
18 hospital at the time.

19 COMMISSIONER McCUTCHEON: You are saying
20 that distinction really cannot be drawn, it is
21 really all a part of the patient care, part of the
22 superior patient care in particular hospitals.

23 DR. BROWN: Exactly.

24 THE CHAIRMAN: Have you ever been able to
25 work out a degree of subsidization that the profession
26 renders to the medical education that way?

27 DR. BROWN: No, I have no figures on that.

28 THE CHAIRMAN: You recognize it as an important
29 or a minor segment?

30 DR. BROWN: It is a large thing, is it not?



1 COMMISSIONER BALTZAN: Dr. Brown and
2 gentlemen, to me it is a very special pleasure to
3 welcome you here today. I would direct your attention
4 to paragraph 3 on page 2:

5 "The Royal College was
6 constituted originally of professors
7 of medicine, surgery, and obstetrics
8 and gynaecology in the Canadian
9 university and subsequently included
10 as chartered members of the
11 distinguished Canadian Physicians
12 and Surgeons."

13 THE CHAIRMAN: Dr. Baltzan, I wonder if you
14 could speak a little louder.

15 COMMISSIONER BALTZAN: Yes, I apologize, I
16 think I am just running down. I think perhaps there
17 are only one or two parts here by following upon that,
18 gentlemen, you, the Royal College differs in your
19 requirements from that of the ancient Royal Colleges,
20 London, England, Edinburgh, upon which these colleges
21 have been modelled. My question is, and it would
22 be good for the members of the Commission, if you
23 would describe in what way you differ from these
24 ancient Royal Colleges in your program for training.

25 DR. BROWN: Yes. The training required by
26 us as opposed to the Royal Colleges of the United
27 Kingdom is longer period of training. None of us,
28 with the exception of some efforts on the part of
29 the Royal College of Surgeons, the Royal College in
30 Edinburgh too, actually provide training, it is for



1 the regulation and requirement of it. I think it is
2 fair to say that with respect to the Royal College
3 of Physicians of London, for instance, the passing of
4 the examination is an indication that a man is
5 mentally equipped and has demonstrated his ability
6 to work in such a fashion that he can be considered
7 to be a man who could go on to complete specialist
8 training if they can pass this examination in a
9 shorter time following an examination than can our men.
10 In this country the thinking is that the passing of
11 the examination, one of the examinations of the Royal
12 College is an indication that a man has completed his
13 specialist training, the minimum requirement at least,
14 and that he is competent at that point in specialty.
15 He is not one who has demonstrated his potentiality
16 which is usually the case with the Royal College of
17 Physicians and Surgeons in London. He is a man who
18 has demonstrated his accomplishments and, as set out
19 in our brief, he has demonstrated his competence in
20 the practice of a specialty. It is a difference in
21 the approach of the two types of colleges to the
22 problem.

23 COMMISSIONER BALTZAN: In other words, may
24 I say, correct me if I am wrong but still pursuing
25 the basic theories, your greater emphasis is on the
26 practical acquisition for useful work as a specialist?

27 DR. BROWN: That is an essential in any of
28 our examinations, an examination for the certificate
29 and for the scholarship.

30 COMMISSIONER BALTZAN: At this stage in your



1 work as a college in Canada the requirements for
2 preparation take something like five years on the
3 average, could you give us what is the average age
4 of a man who is ready to go out and assume his role
5 as a specialist after all these years of training?

6 DR. BROWN: I do not think we have precise
7 figures but it is in the order of 30 years.

8 DR. GRAHAM: My own guess would be around
9 thirty years of age on the average.

10 COMMISSIONER BALTZAN: Earlier, Dr. Brown, you
11 were saying whether this new hospitalization
12 would affect the specialization and the things that
13 lead up to acquiring requirements of a specialist.
14 Have you heard or do you know of what has happened in
15 England in relation to the number of specialists under
16 the new scheme as prior to the British National Health
17 scheme? Let me help you a little by saying that I
18 have knowledge to the affect that there are more
19 specialists following the institution of the British
20 National Health service in proportion to general
21 practitioners than before; am I right or do you know?

22 DR. BROWN: I do not know, sir.

23 COMMISSIONER BALTZAN: I will have to take
24 what I read.

25 DR. BROWN: Yes. I have that information.

26 THE CHAIRMAN: That depends on what you have
27 read.

28 COMMISSIONER BALTZAN: Now, we will go
29 back to page 13, the last portion of paragraph 47:
30



1 "Although such approval was
2 fully justified by the applications
3 of these hospitals, certain trainees
4 elected to move each year from one
5 such hospital to another with
6 similarly restricted privileges.
7 This practice resulted in a
8 fragmentation of training, and
9 usually interfered with the increasing
10 responsibility for patient care, which
11 is the key note of a satisfactory
12 residency training program. Steps
13 are being taken to discourage this
14 practice, which is not considered
15 to be in the best interest of the
16 trainee."

17 You then advocate that a man begin his
18 training in one institution and proceed to completion
19 without necessarily going to broaden his experience
20 elsewhere?

21 DR. BROWN: No, not exactly that. We do,
22 in so far as we are asked for our advice by candidates
23 advise them to take the greater portion of their
24 training in one institution or under the auspices
25 and guidance of one group. At the same time the
26 advice is usually given people by professors of
27 medicine and surgery and others that they should go
28 somewhere else for at least one year of their
29 experience but this is in contrast to the successive
30 one year stands where a man has just one year in each



1 of the four or five hospitals. This we do not think
2 is a good thing for the reason that we set out on
3 page 35:

4 "An essential part of graduate
5 education in the clinical specialties
6 is graded responsibility for patient
7 care under expert supervision."

8 If a man stays for three years in one hospital
9 his responsibility increases a great deal over that
10 period of time and his responsibility in his third year
11 therefore, is almost always higher than is the
12 responsibility of a man who has spent his single years
13 in three successive hospitals.

14 COMMISSIONER BALTZAN: In taking that as
15 stated, Dr. Brown, have you any form of farming such an
16 individual out to an area where he could then not go
17 over the same thing but then proceed after his three
18 years at a higher level?

19 DR. BROWN: The college itself can do only
20 very limited work at this. We can refuse to approve
21 a scheme of training which a man submits, there is
22 this negative way of approaching it. He may be
23 given advice which is informal and unofficial, this
24 is the sort of thing which must largely be done by
25 heads of clinical departments and heads of university
26 departments from whom the trainees seek advice locally.

27 COMMISSIONER BALTZAN: Perhaps I should
28 enlarge my knowledge of this. May I ask a question
29 of Dr. Janes and ask if he remembers in the beginning
30 there was an allowance made, if I remember correctly,



1 that during the course of training, especially toward
2 the end of his time for preparation for his
3 fellowship that an individual could elect one year's
4 apprenticeship with a qualified recognized fellow of
5 the College and that year would be recognized as part
6 of the training.

7 DR. JANES: That applies to certification
8 but it never applied to fellowship.

9 COMMISSIONER BALTZAN: It never did apply?

10 DR. JANES: No.

11 COMMISSIONER BALTZAN: And does it still apply
12 to specialization?

13 DR. JANES: It is still not allowable for
14 fellowship. The tendency -- I am no longer a member
15 of council -- is to make the training towards the
16 certificate approach more nearly to that required for
17 fellowship. Am I right?

18 DR. BROWN: Yes, our changing policy with
19 this respect and changing regulations gradually, and
20 in some specialty, the training requirements are the
21 same for the certification examination as for the
22 fellowship examination. In these cases, of course,
23 the opportunity of doing what you call a year of
24 supervised practice as part of the training for the
25 certificate has disappeared, it no longer exists.
26 The three specialties in which this has been accomplished
27 were the specialties of anaesthesia, general surgery,
28 obstetrics, gynaecology, otolaryngology, and psychiatry.
29 In some specialties the certification examination has
30 been done away with altogether. We are moving in



1 this respect and moving, I might say, quite slowly.
2 There are, further, still men having their training
3 approved under the old regulations which permitted
4 this year you mentioned because they commenced their
5 training during this period that these regulations
6 were still in force.

7 COMMISSIONER BALTZAN: I won't ask you to
8 project yourself to the future but it is likely that
9 the same thing might be revised because it is bound
10 to be helpful in the development of the individual to
11 have that contact which you fear might be lost under
12 any new scheme of hospital restrictions where the
13 individual could then have personal contact with an
14 older person and gain that which he probably misses.

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1 DR. BROWN: Yes, I think, sir, that
2 there was quite a feeling that ideally this was a good
3 thing. That is, if it worked out ideally it would be
4 a good thing.

5 It was the experience, however, that
6 very often it was not a very good thing because it was
7 not what both of us are thinking of at the moment.
8 It was something very much short of that and the master-
9 apprentice connection, if you like to describe it that
10 way, was a pretty tenuous one and this is one of the
11 reasons why the year has been abandoned.

12 COMMISSIONER BALTZAN: I want to thank
13 you for including me in your thinking. I am not trying
14 to be facetious. I do want to pursue one or two other
15 things if I may, Mr. Chairman.

16 Page 18, No. 65:

17 "In the event that medical services
18 insurance should be made available to
19 all Canadian citizens, the problem of
20 obtaining an adequate number of patients
21 for teaching will become more urgent
22 unless certain appropriate measures
23 are taken".

24 I wondered, gentlemen, whether that
25 really poses the kind of suspicion and fear that you
26 might have in mind.

27 Now, you heard from Dr. Wendell Macleod
28 a while ago and he spoke of the University Hospital where
29 the patient assigns himself over, as it were, to be a
30 factor in the teaching program, allowing certain things



1 in the way of supplying himself as teaching material. Do
2 you think that this sort of restriction, because a patient
3 becomes a private patient, is really the important thing?

4 If the teachers took on the new attitude
5 towards a new - I don't like to use the word social
6 order, but a change in our system and in our way of life
7 where these people are not any more the social drags in
8 society, where there are not any more people coming from
9 the slums upon whom we have learned what we know; if the
10 teaching attitude changes correspondingly, whether this
11 factor will not actually be a deterrent factor?

12 DR. BROWN: Certainly the attitude of
13 teachers will have to be different from what it was 20
14 years ago and it has changed a very great deal. There
15 are different types of problems here and it is difficult
16 to generalize about them.

17 We have heard from Dr. Macleod and his
18 experience in Saskatoon. I would like to ask Dr. Webster
19 if he would comment on your question now because he is
20 head of a large teaching department in the hospital which
21 did not start out as a complete teaching unit but has had
22 to bridge the gap, and I would like to ask him to speak
23 now.

24 DR. WEBSTER: Mr. Chairman, Dr. Baltzan,
25 certainly we have only had a year's experience of hospita-
26 lization in Quebec Province but I would take a little
27 umbrage at the President's remarks here because the Royal
28 Victoria Hospital has always been a teaching hospital
29 since its inception.

30 DR. BROWN: I already realized I left



1 out the key clause.

2 DR. WEBSTER: We formerly had large
3 public wards where the undergraduate and post-graduate
4 training was done but under a new construction there
5 has been a tremendous increase in the number of semi-
6 private beds and in the demand available.

7 I do not think there is any difficulty
8 in using semi-private or private patients for under-
9 graduate teaching, as long as the load is not too great
10 on the patient. In all my years of experience, I can
11 count on the fingers of two hands those patients who
12 have refused to be used for clinical demonstrations but
13 in the field of graduate training, especially the surgical
14 specialties, there is an additional burden on the teacher and
15 on the patient and that is besides teaching the philosophy
16 of the disease, you have also to teach the manual skills
17 and in such instances, if we are to be forward about it,
18 the patient must be prepared to accept the trainee as the
19 surgeon who operates on them.

20 This is difficult to achieve possibly
21 with the semi-private patient in our present environment
22 but as more and more the idea of teamwork is integrated
23 in the institution I think this may be alleviated
24 considerably.

25 We do not believe that there should be
26 a poverty-stricken segment of the population in order to
27 train young surgeons but as our prosperity grows these
28 people must be made available with increasing responsi-
29 bility as the surgeon progresses in his training and that
30 the patient should be willing to accept him as his



1 operating surgeon but this needs considerable development,
2 as such.

3 As it is said in the brief, teaching
4 units must be made attractive and staffed well and very,
5 very properly handled - almost a revolution in our idea
6 of handling the teaching units in the hospital.

7 COMMISSIONER BALTZAN: Thank you, and
8 you also anticipated my next question which deals with
9 surgery, talking about surgery.

10 In respect of that, you are encountering,
11 and teaching is encountering, a great difficulty. Is
12 that a matter for hospitalization and even for the imple-
13 mentation of the new approaches, etc; but isn't there
14 also involved there a question of a legal problem that
15 perhaps counsel would have to come into?

16 It has been considered in other centres
2 17 all these provisions of security, and under the auspices
18 of the trained individual, and yet the contract between
19 patient is with the physician and therefore he cannot
20 delegate, except under given circumstances, and that
21 would require some legal straightening out before that
22 can be made fully applicable. Am I right?

23 DR. WEBSTER: That is quite true, sir.
24 We have had under study for over two years by the legal
25 authorities the proper kind of consent document that
26 would be acceptable to both parties.

27 COMMISSIONER BALTZAN: I hope I don't
28 come under the judgment of the Chairman of the Commission
29 some time.

30 THE CHAIRMAN: I hope not.



1 COMMISSIONER BALTZAN: You have been
2 very kind, and thank you very much. I think you have
3 helped the Commission to understand a good number of
4 things. One other thing - I thought I was through;
5 as specialists you speak of referral of patients. I
6 think everybody understands that. Do you advocate such
7 patients be received by specialists only on referrals
8 or should they also have freedom of choice to select for
9 themselves the right to go to, say, a specialist even if
10 their choice is a wrong one?

11 DR. BROWN: Well, Dr. Baltzan, Mr.
12 Chairman, this was discussed thoroughly by the Council
13 of the College a number of years ago and it was decided
14 then that no restriction would be placed on our fellows,
15 on the certificant, in this respect.

16 This discussion took place some time
17 ago. It is our feeling now, however, that in thinking
18 about the question which you raise, one must divide the
19 specialties into different groups, for instance, with
20 respect to the auto larynologist is perhaps different
21 than the surgeon in the smallish town or in the big town,
22 the man has a patently E.N.T. problem he will resent
23 having to pay a fee to a general practitioner simply to
24 be referred to the specialist he knows he is going to go
25 to anyway.

26 The problem of some of the other
27 specialists whose breadth of work is greater is more
28 complicated and we think that there is room at the
29 present time in the changing pattern of practice that
30 we are seeing for specialists, who do both types of work;



1 the specialist who does strictly referral work and the
2 specialist who is not confining himself to referral work
3 but who at the same time is seeing patients still
4 strictly within his field who have come to him without
5 referral.

6 COMMISSIONER BALTZAN: My very special
7 reason for asking this question is because it has come
8 before this body this very same question in respect to
9 dealing with prepaid voluntary health service and some
10 insist that only the referral patient be recognized as
11 one entitled to benefits by that organization and if he
12 is not referred, then he is not entitled so I think it
13 will still have to be searched what the right answer
14 will be to that. That is the reason why I raised that
15 question. Thank you.

16 COMMISSIONER VAN WART: Dr. Brown,
17 competence is the basis of registration in fellowship.
18 The provinces, in their specialty lists, accept your
19 registration as evidence of being capable of carrying
20 out the specialty. That is true, is it?

21 DR. BROWN: It is true, Dr. Van Wart,
22 from B.C. through to Ontario. Quebec has its own
23 examinations and it does not accept the certificate or
24 fellowship of the Royal College as being a registerable
25 qualification with respect to the specialty registry in
26 Quebec despite that a large part of the specialists in
27 Quebec do have and have passed the examination of the
28 College.

29 In the Maritime Provinces, as you know,
30 the situation is less definite and they have not defined



1 their policy as concretely as some of the other provinces.

2 COMMISSIONER VAN WART: Do many of the
3 hospitals accept for appointment the fact that they are
4 registrants or fellows, accept that as evidence so that
5 they can carry out their specialty in that hospital?

6 DR. BROWN: More and more it is becoming
7 an essential part of hospital bylaws that members of the
8 so-called attending staff, those who are going to prac-
9 tise a specialty, have the certificate or fellowship of
10 the College.

11 In some cases it reads "or an equivalent
12 qualification".

13 COMMISSIONER VAN WART: Well, does your
14 body over, say, 10 or 15 years later review the competence
15 of those whom you have qualified?

16 DR. BROWN: No sir.

17 COMMISSIONER VAN WART: But still the
18 hospital or the provinces accept membership in your
19 organization as a means of carrying out their specialty
20 provision?

21 DR. BROWN: Yes.

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1 COMMISSIONER VAN WART: In ten or fifteen
2 years' time, through lack of post graduate training
3 or something else, they go down and they still accept
4 your original certification?

5 DR. BROWN: Yes.

6 COMMISSIONER VAN WART: Is that not a
7 defect in your organization?

8 DR. BROWN: Yes. In the pattern of medical
9 services, we have known it recently, at any rate, the
10 check in this respect, both the MD qualification and
11 specialist qualification, has been at the local level,
12 hasn't it, and the check has been based on the man's
13 performance in the hospital in his own community, and
14 when this has fallen below the standard to be clearly
15 measured, then steps are taken. But there is not
16 a review of professional competence by the College
17 any more than there is a review by medical schools of
18 the man to whom they gave an MD fifteen and twenty years
19 ago.

20 COMMISSIONER VAN WART: You have no means of
21 striking a member off your fellowship list, your by-laws?

22 DR. BROWN: Yes, there is an entire section
23 of the by-laws dealing with matters of discipline.
24 There is a means there to remove a man's name from the
25 register.

26 COMMISSIONER VAN WART: Is that only confined
27 to a criminal judgment against him in the courts, or
28 is there other provision?

29 DR. GRAHAM: The section is Article 7
30 of the by-laws in Exhibit A, our constitution by-laws



1 on page 23.

2 DR. BROWN: It is misconduct in a professional
3 respect.

4 COMMISSIONER VAN WART: Not on competence at
5 all?

6 DR. BROWN: Well, this is still an open
7 question. If a man were grossly incompetent professionally,
8 then it is the claim of some that this could be
9 considered misconduct.

10 COMMISSIONER VAN WART: It is a more a
11 misdemeanour and not competence?

12 DR. BROWN: And certain professional mis-
13 demeanours, if you like, or coming short in certain
14 professional respects; I think this might well be
15 construed as misconduct.

16 THE CHAIRMAN: We are going to have a few
17 minutes recess.

18 ---Short recess.

19 COMMISSIONER FIRESTONE: Mr. Chairman, and
20 Dr. Brown, I would like to congratulate you, like the
21 Chairman did, and your colleagues on the calibre of
22 your brief, both with respect to quality and clarity.
23 The brief is written clearly and to the point and
24 easily understandable by the layman. The brief proves
25 that doctors and laymen can speak the same language.

26 May I turn to page 6 of your brief, paragraph
27 20, in which you indicate that among the different
28 requirements for admission you require also graduation
29 from a medical school acceptable to the College. What
30 medical schools are acceptable to the college?



1 DR. BROWN: Dr. Graham, could you mention,
2 at any rate, to start the answer to this question, the
3 lists from which you work when you have in front of
4 you graduates from outside of the country?

5 DR. GRAHAM: Mr. Chairman, the medical
6 schools of Canada which provide the bulk of our
7 candidates include the medical schools in the United
8 States, United Kingdom, France and the better known
9 medical schools in Europe. Some difficulties do
10 arise in some of the medical schools elsewhere in the
11 world, I must confess, and I think it is quite true
12 to say that there is not a comprehensive list of
13 approved medical schools which covers the world. We
14 have a list published by the World Health Organization,
15 and this is not necessarily a list of schools which
16 would be approved. In the case of these institutions
17 we think are less well known to us, on the whole it
18 is not a major problem, I would say.

19 COMMISSIONER FIRESTONE: Does the Royal
20 College publish a list of what you call medical schools
21 acceptable to the College?

22 DR. GRAHAM: We have not done so, sir.

23 DR. BROWN: No.

24 COMMISSIONER BALTZAN: Excuse me, Dr. Graham,
25 we have what is called the Canadian Medical Association,
26 American Medical Association Accreditation of Schools.

27 DR. GRAHAM: There is a list of the Canadian
28 medical schools approved, Association of Canadian
29 Medical Colleges and the American Medical Colleges.

30 COMMISSIONER BALTZAN: There is not a comparable



1 thing for European or Continental schools, comparable
2 list?

3 DR. GRAHAM: Not to my knowledge.

4 COMMISSIONER BALTZAN: A world list of schools.

5 DR. GRAHAM: The only world list is the one
6 I referred to, W.H.O., and it is not an attempt to
7 approve or disprove of these schools.

8 COMMISSIONER FIRESTONE: Therefore is
9 somebody wants to obtain certification, become a fellow,
10 he would have to find out from the College whether this
11 particular medical school is on your approved list;
12 is that correct?

13 DR. GRAHAM: That would be correct, yes.

14 COMMISSIONER FIRESTONE: Would you include, for
15 example, the University of London Medical School in
16 your list?

17 DR. GRAHAM: Yes.

18 COMMISSIONER FIRESTONE: Would you include
19 the University of Paris?

20 DR. GRAHAM: Yes.

21 COMMISSIONER FIRESTONE: Have you run into
22 any difficulties or complaints from some of the
23 applicants that some universities are omitted from
24 what you consider university desirable standard?

25 DR. GRAHAM: I can't say I have encountered
26 this, no.

27 DR. BROWN: No. It is a requirement, as
28 has been stated, but the problem of someone getting to
29 this stage of graduate training who hasn't come from
30 a decent medical school has not been part of our



1 experience, fortunately.

2 COMMISSIONER FIRESTONE: That is fortunate.
3 In paragraph 21 you say that at least two years must
4 be spent in an approved hospital training in the chosen
5 specialty. What is the basis upon which you
6 designate a hospital as an approved teaching hospital?

7 DR. BROWN: Now, Dr. Firestone, with your
8 permission I would like to ask Dr. Thompson to speak
9 to that, because he has been associated with our
10 committee on approved hospitals for graduate training
11 for a great number of years and brought it from sketchy
12 and incomplete beginning to the rather well developed
13 form it is in now.

14 COMMISSIONER FIRESTONE: Dr. Brown, would
15 you feel free to ask any of your colleagues to answer
16 the questions, if you wish.

17 DR. THOMPSON: May I have the question again,
18 sir?

19 COMMISSIONER FIRESTONE: In paragraph 21
20 you say:

21 "At least two years must be
22 spent in approved hospital training
23 in the chosen specialty..."
24 My question is, what is the basis upon which you
25 designate the hospital as an approved teaching hospital?

26 DR. THOMPSON: This program began in 1947
27 without some of the developments that have come about
28 over the years. In the regulations of the college
29 for each specialty there are definite statements to
30 the effect that two years should be spent as socalled



1 core years in approved hospitals for training. Now,
2 when we are dealing with about twenty-two
3 specialties through the specialty committees we have
4 evolved a basis of minimum requirements for hospital
5 approval in these various specialities, and it is on
6 this basis that these approvals are granted. In
7 addition to that an inspection in recent years has been
8 carried out on our behalf by the Canadian Hospital
9 on Accreditation.

10 COMMISSIONER FIRESTONE: Do approved hospitals
11 cover hospitals in Canada only?

12 DR. THOMPSON: We have not extended, except
13 in rare instances, our approvals beyond this country.

14 COMMISSIONER FIRESTONE: Thank you, sir.
15 Turning now to paragraph 31, Dr. Brown, in which you
16 speak about a fund that has been established, the
17 income of which is used to support and expand the
18 educational functions of the college, to promote
19 regional meetings, to provide scholarships and bursuries
20 to allow the Fellows of the College and others to
21 pursue further graduate medical studies. You are
22 making some recommendations a little later on about
23 the desirability of increasing scholarships and
24 bursuries. May I ask you in this connection what
25 your experience has been with the scholarships and
26 bursuries which you are already offering? Are the
27 numbers adequate, are amounts adequate? What has
28 your experience been?

29 DR. BROWN: It is purely speculative so far.
30 The fund is not large enough to change the tense of



1 this verb in this sentence. The College has not so
2 far offered scholarships and bursaries. It has
3 used funds from this particular fund and income from
4 other sources to promote regional meetings which are
5 held in towns other than the town in which the annual
6 meeting is held, and it has funds for support of
7 a travelling professor, one each year. The provision
8 of scholarships and bursaries which may be used to
9 further graduate studies at the present time remains
10 a hope.

11 COMMISSIONER FIRESTONE: In other words,
12 your suggestion is that the government ought to
13 contribute, provide funds for scholarships and
14 bursaries, if I understand your recommendations
15 correctly.

16 DR. BROWN: We think there is a need, sir,
17 for funds to enable properly qualified people to
18 complete graduate training in the clinical field.

19 COMMISSIONER FIRESTONE: Could you advise
20 this Commission of what you would consider would be
21 an adequate scholarship which would enable a graduate
22 in medicine trying to become, develop some knowledge
23 of the field, specialist field? What would be a
24 reasonable amount to pay for his fees and his living
25 expenses, say, for one year, at the graduate level,
26 assuming that many of them might be married?

27 DR. BROWN: Yes. There are so many factors
28 to be taken into account here, and many of the
29 provisions at the moment are inadequate. There are
30 certain goals which one might think would be achievable,



1 and one might make comparison with the provision by
2 the government for a PhD. Now, the PhD. as a rule
3 has spent the same time as the MD and has not embarked
4 on his post graduate training; it may be said that
5 he is still in training, but he is making quite a
6 valuable contribution at the same time. These
7 are perhaps comparable.

8 Now, the National Research Council, for
9 instance, has a schedule of salaries for PhD's, and
10 it begins at \$6,000.00. Now, this is a comparison
11 which might be made, and one might think this was
12 an adequate thing. But we think that this sort of
13 level should be moved to as rapidly as possible.

14 COMMISSIONER FIRESTONE: What would you start
15 out a young graduate -- are you talking now of a more
16 mature person who is trying to enter the field of
17 the specialties or are you talking about graduate
18 studies of the younger man, twenty-six, twenty-seven,
19 as against the man at thirty-five to forty?

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1 DR. BROWN: The more common event I
2 think is the man starting at his senior internship.

3 COMMISSIONER FIRESTONE: How old would
4 he be?

5 DR. BROWN: On the average 24 to 26.
6 Occasionally younger, but not often.

7 COMMISSIONER FIRESTONE: What kind of
8 scholarship would you think would be adequate for a man
9 24 to 26, entering on graduate studies for the first year?

10 DR. BROWN: This might be a figure
11 which would make it possible for him to be married, and
12 take his normal place in the social environment, and be
13 a person from thereon, instead of simply a student, and
14 as regards the specific amount, I would like only to say
15 that only very rarely has any hospital approached what
16 is really an adequate amount of money for a man at this
17 stage of his career, which is eight years from matricula-
18 tion.

19 COMMISSIONER FIRESTONE: Would you say
20 that 2,500 or 3,000 dollars would be adequate, or inade-
21 quate, as a start, and graduating as he advances?

22 DR. BROWN: I would say that that
23 should only be the first step.

24 COMMISSIONER FIRESTONE: You would want
25 it to advance to more adequate amounts ---

26 DR. BROWN: And to bring him into line
27 with people in other sciences.

28 COMMISSIONER FIRESTONE: Bring him into
29 line with scholarships available in other sciences?

30 DR. BROWN: Not only scholarships, but



1 recompense available in other sciences after an equal
2 period of training.

3 COMMISSIONER FIRESTONE: Is this compari-
4 son between a graduate student still studying, and some-
5 one having graduated in another science, and therefore
6 being employed? Would you want to equalize the scholar-
7 ship to a salary?

8 DR. BROWN: The resident is a graduate
9 student who must be still studying if he is ever going
10 to pass our examinations, but he is also employed and
11 he is an indispensable member of the hospital team.

12 COMMISSIONER FIRESTONE: Thank you, Dr.
13 Brown, this is very helpful, because you are now putting
14 your finger on the crux of the problem. This graduate
15 needs two sources of income. His salary, which is very
16 moderate, and secondly a scholarship to enable him to
17 have a minimum standard of living, commensurate with the
18 position he occupies?

19 DR. BROWN: I certainly agree at the
20 present time he needs an additional amount, whether the
21 additional money would better come through one route or
22 another is, to a certain extent, an administrative thing.

23 COMMISSIONER FIRESTONE: Looking at it
24 from your view, I take it that if this particular graduate
25 could get a higher salary, this is all you are concerned
26 with, that his income should be adequate?

27 DR. BROWN: Yes.

28 COMMISSIONER FIRESTONE: And if it is
29 not adequate from the source he is getting it from, the
30 supplementary source, such as a scholarship, should bring



1 it up?

2 DR. BROWN: Yes.

3 COMMISSIONER McCUTCHEON: Your primary
4 recommendation, as I understand it, it was residents
5 should be paid an appropriate salary, so that they could
6 be an individual, and that should come from a hospital
7 budget having regard to the service they render. The
8 fellowships would be for post-graduate students who, for
9 the time being, are not engaged in patient treatment?

10 DR. BROWN: For a year maybe, when they
11 are not doing a residency. There are, as you pointed
12 out, several different types of activity during these
13 4 to 5 years of graduate work, and they must be paid for
14 it in different ways.

15 COMMISSIONER FIRESTONE: We were talking
16 about the young man who is employed, and who gets a
17 certain income, which is considered inadequate?

18 DR. BROWN: Yes.

19 COMMISSIONER FIRESTONE: Is your sugges-
20 tion, sir, that there should be a supplementary scholar-
21 ship to bring this up to a more adequate level?

22 DR. BROWN: No, the suggestion is what
23 is in the brief, that this should be part of the opera-
24 ting costs of the teaching hospital, and you asked me if
25 I thought the other would be desirable, if it couldn't
26 be done in the teaching hospital budget, and I said yes,
27 if it was really impossible to do it in the budget, let's
28 do it some other way, but the recommendation of the brief
29 is that the proper remuneration of residents should be
30 the responsibility of the teaching hospital, through its



1 ordinary budget.

2 COMMISSIONER FIRESTONE: But you under-
3 stand, sir, the practical difficulties that the Government
4 of Canada faces, and we are concerned here in offering
5 advice to the Federal Government on what the system
6 would be.

7 Under The Hospital Insurance and Diag-
8 nostics Act, the Federal Government makes financial
9 contributions to provinces, who in turn pay the cost of
10 hospital insurance, and the provincial and regional
11 hospital commissions are making the decisions as to what
12 the relationships with these people should be, therefore
13 the Federal Government has no way, under the existing
14 system, to achieve the objective you stated, and I am
15 asking you to offer some advice as to how, under the
16 existing system or perhaps a changed system, your objec-
17 tive could be achieved?

18 DR. BROWN: It could be achieved by a
19 change in attitude on the part of the provincial commis-
20 sions.

21 COMMISSIONER FIRESTONE: You are advi-
22 sing a Royal Commission, who in turn will be advising
23 the Federal Government, which has no control over the
24 attitudes of provincial commissions. Have you any
25 suggestions to make how either the Federal Government
26 could contribute to changing those attitudes, or devise
27 another system to achieve the objective stated in your
28 brief?

29 DR. BROWN: I would like to say first
30 of all I hope it would not come to that. This complicates



1 things. A man is doing one job and getting paid from
2 different sources. What other sources might it come
3 from? We cannot pretend to have studied that, or to
4 suggest other methods of remuneration, which would be
5 at all appropriate, and our comments on that would be
6 those of the inexperienced.

7 COMMISSIONER FIRESTONE: If I then can
8 restate my understanding of the principle, you still
9 would like to see a system devised that would provide
10 for adequate remuneration of these people, including
11 using whatever methods are most appropriate to achieve
12 this objective?

13 DR. BROWN: Yes.

14 COMMISSIONER FIRESTONE: That is your
15 principle?

16 DR. BROWN: Yes.

17 COMMISSIONER FIRESTONE: Thank you very
18 much. Have you any ideas, or any suggestions, sir, about
19 the need for scholarships and bursaries in Canada for
20 graduate training, the numbers that might be involved?

21 DR. BROWN: No, we don't have figures
22 on that. We are stating the principle here, and the
23 reasons why we think the principles are good ones. The
24 size of this problem we have left to others, some of
25 them your own people, and others who will be submitting
26 briefs to you.

27 COMMISSIONER FIRESTONE: May I turn now
28 to paragraph 34, page 9, in which you comment on medical
29 ethics. This Commission has received a number of briefs,
30 sir, a number of points of view have been expressed,



1 either for or against a national medical care plan for
2 Canada. Some of the opponents of such a plan have made
3 many points, but I would like to mention just two,
4 because they have a bearing on paragraph 34 of your
5 submission.

6 We have encountered suggestions that
7 if a national medical care plan were introduced of one
8 form or another, that this may affect the quality of
9 medical care services, and secondly, lead to misuse, or
10 over-utilization of medical care services.

11 Now, my questions, Dr. Brown, relate
12 to the fellows of your own College, and I do not ask you
13 to offer any comments as they are applicable to the
14 medical profession as a whole.

15 My first question relates to quality.
16 The suggestion has been made that once we have such a
17 national medical care plan the quality of medical service
18 would suffer. Presumably this applies to also the
19 fellows and specialists who are members of your College.
20 Could you offer some comments on that?

21 DR. BROWN: No, I cannot, Dr. Firestone.
22 This has not been something on which the College or its
23 Council has spent time. We have not developed an opinion
24 on this point, and therefore I cannot give you one.

25 COMMISSIONER FIRESTONE: Can I talk
26 about this question then of over-utilization? The
27 suggestion has been made that such a plan might bring
28 over-utilization. It has been described as a misuse of
29 the plan, over-utilization. Presumably over-utilization
30 takes place when a physician performs services beyond



1 what good medical practice would require.

2 Now, would it not be true that your
3 fellows, as your paragraph 34 says, are required to
4 sign a statement that their professional conduct will
5 be guided by the Code of Ethics adopted by the College,
6 and presumably your College would frown on what has been
7 described as misuse, or over-utilization by asking the
8 patients to come back unnecessarily, or performing
9 surgery that is not necessary.

10 Would you say that you would not expect
11 the members of your College to practise over-utilization,
12 even under a national medical care plan, simply because
13 they have given this undertaking?

14 DR. BROWN: Yes, I think, Dr. Firestone,
15 we can leave the matter of a national plan out of it
16 altogether, because it does not really affect the issue.

17 COMMISSIONER FIRESTONE: Except that
18 this is the comment that has been made to the Commission,
19 that such misuse or over-utilization would take place
20 under such an arrangement, and not under normal practice,
21 and we would like to have enlightenment whether there is
22 a plan or not whether we have to worry about it.

23 DR. BROWN: My comments are made aside
24 from any hypothetical plan. The second thing is this,
25 that over-utilization is a function of a patient, and not
26 the doctor. It is the patient who is using the services,
27 so that perhaps the question boils down to the provision
28 of unnecessary, and indeed, damaging medical services.
29 It doesn't matter what the system is. This is not
30 ethical conduct, but please note that I have separated



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1 altogether from the word "over-utilization" which is a
2 function of the customer, a function of the patient,
3 and not a function of the doctor.

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1 COMMISSIONER FIRESTONE: Well now, without
2 endeavouring to engage in a discussion on semantics,
3 I take it if over-utilization is used in the sense
4 that the patients are dropping in to see him more
5 often than the doctor thinks necessary and the doctor
6 accedes to this request, would you feel that he is not
7 acting in accordance with the statement which he
8 signed when he accepted the fellowship from your
9 college since he signed the statement that he would be
10 guided by the code of ethics?

11 DR. BROWN: Yes, after about a fortnight's
12 investigation to find out the merits of the case we
13 would be prepared to arrive at a decision.

14 COMMISSIONER FIRESTONE: In any event, you
15 are saying that you have the machinery to deal with
16 such a situation as and when it would arise but
17 you do not expect it to arise.

18 DR. BROWN: No, I did not say what I expected.

19 COMMISSIONER FIRESTONE: Would you like to
20 put it.

21 DR. BROWN: I said the machinery is there
22 to deal with it if it does arise.

23 COMMISSIONER FIRESTONE: Let me put it in the
24 form of a question; do you expect this to arise
25 frequently?

26 DR. BROWN: In what circumstances?

27 COMMISSIONER FIRESTONE: In the circumstances
28 which I described to you earlier that a patient may
29 be asking a physician to see him more often than is
30 necessary; this is described in layman's language as



1 over-utilization.

2 DR. BROWN: You are describing the events,
3 but not the situation in which it occurs.

4 COMMISSIONER FIRESTONE: I would assume the
5 College would want to judge the circumstances on past
6 merits.

7 DR. BROWN: As I say, the only circumstances
8 I can make any comment on exist now and are not
9 hypothetical circumstances concerning one or other
10 medical schemes. As I pointed out, the College as
11 a body has not developed an opinion about the
12 desirability or otherwise of any form of government
13 medicine.

14 COMMISSIONER FIRESTONE: But you have had
15 very little problems under this particular section of
16 your provisions?

17 DR. BROWN: That is right, sir.

18 COMMISSIONER FIRESTONE: Turning now to
19 page 35, paragraph 110 you say in the first sentence:

20 "The extensive graduate
21 training programs carried out in
22 the university affiliated hospitals
23 involves considerable expense to
24 the medical schools as well as
25 to the hospitals themselves."

26 How do hospitals pay for these expenditures
27 at present?

28 DR. BROWN: This varies from teaching hospital
29 to teaching hospital and I doubt if there is a general
30 policy. There will be some things used in training



1 of the graduate students aside altogether from the
2 mechanics of ordinary patient care which I am sure
3 hospitals manage to provide out of ordinary budgets.
4 Some hospital service commission will make small grants,
5 small training grants for the training of graduates;
6 some hospitals have endowments, some have none.
7 Some teaching hospitals, university affiliated hospitals
8 will get a grant according to some formula or other
9 or perhaps according to no formula, in some cases
10 from the university medical school with which they are
11 associated. The sad part of it is that in the
12 lump these sources are generally inadequate.

13 There is another point to be made: perhaps
14 there has been a tremendous expansion of graduate
15 training in the last fifteen years in Canada and this,
16 to a large extent, has been accomplished on the basis
17 of using capital, so to speak, on the basis of what
18 was there before. The needed expansion, the expansion
19 that is needed in the future in training is not
20 increased. This has to be faced now as well as the
21 refurbishing of all facilities.

22 The answer to your question must be this
23 varies greatly from teaching hospital to teaching
24 hospital.

25 COMMISSIONER FIRESTONE: The conclusion
26 that you have drawn from the medical college which
27 you have answered my question with was, I think,
28 contained in the sentence when you pointed out that
29 amounts in total available are inadequate.

30 DR. BROWN: Exactly.



1 COMMISSIONER FIRESTONE: Now, have you
2 any suggestions as to what amounts you would consider
3 adequate or whether there is a method of assessing
4 what is adequate. Secondly, how should such amounts
5 be financed?

6 DR. BROWN: The first part of the question
7 is no. Again, the total amount of money involved here
8 must obviously be very large over a period of years.
9 We do not know, we have not estimated and we are not
10 competent to do it. We know that others are active
11 so we have not a figure, even the roughest sort of
12 figure, no.

13 COMMISSIONER FIRESTONE: I take it it would
14 go into the millions?

15 DR. BROWN: Oh yes, if one could draw
16 attention to the now outdated recommendations of the so-
17 called Farquharson committee, they recommended that
18 \$12,000,000.00 be provided for the creation of physical
19 research facilities in affiliation with the equipped
20 teaching hospitals and to use Dr. Farquharson's
21 own words, "These are too small now".

22 COMMISSIONER FIRESTONE: That is capital
23 only in addition to what is operating?

24 DR. BROWN: This was simply for the building
25 of buildings.

26 COMMISSIONER BALTZAN: You have one bit of
27 a yardstick in relation to the higher costs of teaching
28 hospitals versus non teaching and that is as we
29 gathered throughout our visits that the university
30 hospitals and the teaching hospitals have a longer



1 day stay per patient and that in itself immediately
2 mounts the cost of a teaching hospital. That is
3 one yardstick for the increased cost of teaching
4 hospitals providing post-graduate work, etc.

5 DR. BROWN: Yes, this partly increases
6 cost and it is based, of course, partly on the fact
7 that the cases referred to teaching hospitals tend
8 to be difficult and expensive cases.

9 THE CHAIRMAN: The mere length of stay, you
10 would have to disassociate yourself from the cost.

11 DR. BROWN: The type of work required to
12 treat this type of case is inevitably more expensive.

13 COMMISSIONER BALTZAN: But it is one item
14 in the increased cost?

15 DR. BROWN: Yes, it is.

16 COMMISSIONER FIRESTONE: Now, assuming as
17 a result of the various studies that are being made
18 and the other information you arrived at that amount,
19 have you any comment as to how this should be financed,
20 where it should come from?

21 DR. BROWN: No sir, we have not. We do not
22 presume to give advice as to the best way in which
23 this money should come to us but we do make the plea
24 that it should come.

25 COMMISSIONER FIRESTONE: I take it since
26 you are making this recommendation to a Royal
27 Commission which is advising the federal government,
28 part of that plea anticipates that this point will be
29 taken up and perhaps recommendations made to the
30 federal government to contribute?



1 DR. BROWN: Yes.

2 COMMISSIONER FIRESTONE: Would you welcome such
3 a contribution?

4 DR. BROWN: We would welcome any improvement
5 that is brought about as a result of the recommendation
6 of this Commission and consider it an important thing.

7 COMMISSIONER McCUTCHEON: You are willing
8 to take money from almost any source?

9 DR. BROWN: We will take it from almost any
10 where and redeem it if necessary.

11 COMMISSIONER FIRESTONE: As long it is
12 designed to serve the purposes you have outlined in
13 your report there are no strings attached?

14 DR. BROWN: The purposes are pretty definite.

15 COMMISSIONER FIRESTONE: That is why I
16 complimented you at the beginning because you are
17 very specific on what you want.

18 Now, turning to page 37, paragraph 116 you
19 mention one of the most fundamental requirements of
20 our medical care program for Canada where you say:

21 "The health care of the people
22 of a country will not in the long
23 run be better than the provision
24 which that country makes for
25 medical research."

26 This, to me, is a very fundamental statement
27 of objective. Now, when you speak here of medical
28 research you have in mind both basic research and
29 applied research?

30 DR. BROWN: Yes, both.



1 COMMISSIONER FIRESTONE: When you speak of
2 both basic and applied research do you have in mind
3 that Canada should try to pursue research in the
4 medical field in all areas or would you feel that
5 a limited number of specialists, resources, capital,
6 etc. You would be better advised to specialize in
7 a number of fields to do a first rate job rather
8 than trying to cover the waterfront?

9 DR. BROWN: Obviously the money diverted
10 to research workers should go to those workers who
11 are producing. It is these people when applying to
12 different bodies for research funds who should be
13 heard most sympathetically and get more money. In
14 the actual mechanics of the getting of research funds
15 at the moment lies the answer to your question and
16 the safeguard against unwise diffusion because money
17 is given to workers for jobs that they are doing and
18 it is given to them on the basis chiefly of their
19 accomplishment up to that point and only for a very
20 short time, of course, on the basis of promise only.
21 There is not in actuality much possibility of spending
22 money where there is not already work in that field
23 in Canada and there is a builtin safeguard there
24 against diversion of funds to fields in which there
25 are not people. It just won't happen at the present
26 time.

27 COMMISSIONER FIRESTONE: Now, to follow
28 on this discussion may I refer you to paragraph 118
29 on page 38 where you say:

30 " Canada, however, lags



1 in its efforts in medical
2 research. More funds, more space
3 and more scientists are required
4 if we are to do what is necessary."

5 Then you go on and say:

6 "A full research effort in
7 proportion to our resources is
8 required if standards of health
9 care in Canada are to be what they
10 should be."

11 Now, it would be very helpful to this
12 Commission if you could explain to us a little what
13 you mean when you say a full research effort in
14 proportion to our resources is required. How does
15 one assess a full research effort in proportion to
16 our resources? We agree, perhaps some of us may
17 agree, that that is probably being very sound but we
18 want to see how it could be translated from principle
19 into practice with perhaps a recommendation to the
20 Canadian government.

21 DR. BROWN: The first thing I have to say
22 is that it is far from a simple affair. When one thinks
23 of our resources in connection with the full research
24 effort it is superficiality to simply talk of gross
25 national product and that sort of thing and say that
26 some other country spends this percentage of it
27 in research and we are away down. That is only
28 one factor. The resources that have to be taken
29 into account the availability of trained people on
30 whom it would be profitable to spend money, the number



1 of trainees or people being trained in research,
2 in the pipeline, who could be expected to be available
3 in three, five or seven years. Space that is
4 available for those people to work in and even in
5 Canada the library facilities for scientists. This
6 is not a full list but when we mention resources there
7 we had in mind at least all these things and had in
8 mind that this picture changes from year to year
9 and what is satisfactory research efforts now perhaps
10 will not be so three or five years from now. You
11 will recall that the Farquharson committee made
12 quite limited but definite recommendations about the
13 extent to which the annual budget of the medical
14 research council ought to be increased.



1 They indicated that these annual incre-
2 ments should increase in size as years went by. Now,
3 the first annual increase mentioned in the Farquharson
4 Report is actually relatively small; took into account
5 the availability of resources of people and laboratories,
6 and so on. There is no glib answer then to the question
7 if it were to be asked; what is a full research effort
8 in Canada at the moment? Very complicated thing to
9 answer.

10 COMMISSIONER FIRESTONE: It is not so
11 much necessarily an endeavour to get an answer of what
12 would be a desirable level of research spending and
13 research effort at this point in time. What we are
14 after is to offer advice to the Government on how it
15 might develop a research program over a long period of
16 time, what sort of resources it might devote in developing
17 it.

18 It is not a program for tomorrow but a
19 long-term program. Is there any guidance one can offer
20 the Government that is a little bit more specific than
21 the phrase "Research effort in proportion to our resources"?
22 Can one say, for example, that as a minimum certain per-
23 centage of medical care expenditures in Canada should
24 be devoted to medical research, that the adequacy or
25 inadequacy of this proportion be reviewed every three or
26 five years in the light of existing resources?

27 I am looking for something that is
28 practical, that governments can follow if they accept it,
29 or if they do not accept it, they pay no attention to it,
30 but at least you offer some concrete guidance. Can we



1 have some views from you?

2 DR. BROWN: Well, I would have two
3 comments and I would certainly agree this is a job to
4 be done three to five years. It's a changing thing.
5 The second is that it is a tremendous job and this is
6 one which should be done by our most knowledgeable
7 people with respect to what is going on in research in
8 the intervals.

9 I would forecast that they would not
10 work from percentage figures of treatment and cost at
11 all. They would go at it from the other side and say
12 "Perhaps this is the amount of money that we can wisely
13 spend with the men we see ahead of us, and the laboratory
14 facilities, and so on and the problems that we see which
15 can be adequate".

16 They would, I think, say that on the
17 basis of this his is the amount of money it would be wise to
18 spend on research in the next period, whatever it is.

19 This thing is worked out to a certain
20 fraction of these treatment costs, or some other figures.
21 These are used for comparison with other countries but
22 this is rather the end of the game, and the beginning is
23 finding out how much money you can spend wisely and this
24 is the way to arrive at it.

25 COMMISSIONER FIRESTONE: Well, that is
26 very helpful, Dr. Brown. Now, if a certain amount of
27 research funds were made available how would they suggest
28 they might be distributed? Have you any advice or
29 guidance to offer to us as to the most effective means of
30 distributing as between research funds made available to



1 an individual scholar, to an individual research project,
2 to a university, or to a university hospital or should
3 a combination of the four methods be used. What would
4 be your advice, sir?

5 DR. BROWN: The money itself at the
6 moment and in the future should go to all these different
7 types of grantees, whether individual or corporative.

8 The expansion of the Medical Research
9 Council, as has been noted in the brief, is something
10 of which we approve and something of which we are very
11 happy and it would be our view that except in special
12 cases the funds from the Federal Government would be
13 most wisely spent through the Medical Research Council
14 which has a long experience on this now and has the
15 machine to do it.

16 COMMISSIONER FIRESTONE: Thank you, Dr.
17 Brown. I am coming now to my last question which relates
18 to page 39, paragraph 119, sub-paragraph 3(d), and I
19 quote:

20 "That adequate funds be provided for
21 the maintenance of active out-patient
22 departments".

23 Dr. Brown, we have had a number of
24 recommendations and suggestions from a number of witnesses
25 that have come before this Commission suggesting that
26 increasing use should be made of out-patient departments
27 in hospitals.

28 You are familiar, I am sure, sir, with
29 the provisions of the Hospital Insurance and Diagnostics
30 Act which permits the provinces to establish and pay for



1 such out-patient facilities, with the Federal Government
2 making close to 50% contribution, but very few provinces
3 in Canada have made use of the existing provisions.

4 Manitoba is one outstanding example,
5 Mr. Chairman. Now, have you any suggestion ---

6 THE CHAIRMAN: Saskatchewan says on
7 the 1st of April.

8 COMMISSIONER FIRESTONE: Saskatchewan
9 says on the 1st of April, according to the Chairman.

10 THE CHAIRMAN: According to the Govern-
11 ment.

12 COMMISSIONER FIRESTONE: As quoted by
13 the Chairman. Would you have any views or suggestions
14 to offer how a piece of legislation which is already on
15 the statute books can be made more effective because
16 this would be a way of providing for what you are asking
17 in paragraph (d), adequate funds?

18 Any suggestion of what we can say to
19 the Federal Government in order to assist the Federal
20 Government to proceed with the implementation of your
21 recommendation under (d)?

22 DR. BROWN: Is this an invitation to
23 re-draft that part of the Act?

24 COMMISSIONER FIRESTONE: No, this is an
25 invitation to help the Commission to make it possible
26 for us to come forward with a concrete proposal for the
27 consideration of the Government of the possible implemen-
28 tation of (d).

29 DR. BROWN: We are in a quandary. We
30 are assured by persons like yourself that there is



1 provision for this type of thing in the Federal Act.

2 It is not for us to get into the problem of the interpre-
3 tation of the Federal Act or the provincial regulations
4 made under their own Act, and so on, but what we do want
5 to point out is that the machine as it exists at the
6 moment in the majority of practice is not grinding finely
7 enough and this is one of the areas of trouble and this
8 interferes not only with the economic provision of
9 medical service to patients, but it interferes with
10 something else which we are not suggesting is more impor-
11 tant, but it is more relevant to our main purpose: it
12 interferes with graduate training and it is a very real
13 problem.

14 There is a special set of problems here
15 quite distinct from the set of problems that have to do
16 with in-patients. As we see it, it is an administrative
17 matter and we do wish people to get together on it.

18 COMMISSIONER FIRESTONE: Thank you, Dr.
19 Brown. You have been a most helpful witness.

20 COMMISSIONER McCUTCHEON: Dr. Brown,
21 can I ask you one question? Assuming, if the Province
22 of Ontario decided to include under the insurance scheme
23 out-patient diagnostic treatment facilities those costs
24 would be shared by the Federal Government. That is a
25 decision for the Provincial Government to make.

26 Assuming they did, is it implicit in
27 your recommendation that you would want an expansion of
28 out-patient facilities? That is what you are saying,
29 isn't it? The out-patient facilities presently existing,
30 no matter who pays for them, are not in your opinion



1 adequate for teaching purposes?

2 DR.BROWN: That is exactly, Mr.
3 McCutcheon, that is the derivation of this recommendation:
4 the trouble with the maintenance, financial maintenance,
5 of the out-patient departments we have now, let alone
6 what they might expect to be if they were expanded.

7 THE CHAIRMAN: Thank you very much, Dr.
8 Brown and your associates and your distinguished colleague
9 from Quebec, Dr. Bergeron. This has been a very helpful
10 and informative session and the information in the brief
11 and the discussion we have had here this morning, the
12 contributions we have had from the various members of
13 your panel, including as well Dr. Webster, also from
14 Quebec, are going to be very helpful. We appreciate
15 your attendance here knowing that you are all distin-
16 guished men in the practice of medicine in Canada and
17 that you put a lot of time and you have been of great
18 help to the Commission. Thank you very much.

19 We will now recess until 2.30 p.m.

20
21 --- Luncheon adjournment.
22
23
24
25
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1 ---On resuming at 2:30 o'clock p.m.

2 MR. HALL: Mr. Chairman, the next submission
3 is that of The Professional Institute of the Public
4 Service of Canada, and I would ask that their brief
5 be filed as Exhibit No. 196. Mr. C.F. Gilhooly,
6 the first Vice-President of the Institute, will
7 introduce the members of his delegation and present
8 a summary of the brief and its recommendations.

9 ---EXHIBIT NO. 196: Submission of the Professional
10 Institute of the Public Service
of Canada.

11 SUBMISSION OF THE PROFESSIONAL INSTITUTE
12 OF THE PUBLIC SERVICE OF CANADA

13 APPEARANCES:

14 Mr. C.F. Gilhooly

15 Mr. Gordon A. Asher

16 Miss Evelyn A. Pepper

17 Miss E.M. Gordon

18 Miss Alice K. Smith

19 MR. GILHOOLY: Mr. Chairman, if I may
20 introduce my group. Starting at the far end of the
21 table here is Miss Alice K. Smith, Principal Nursing
22 Officer. Then Miss E.M. Gordon, Supervisor of
23 Nursing Council in the Civil Service Health Department.
24 Miss Evelyn A. Pepper, Nursing Consultant in
25 Emergency Health Service. On my immediate right is
26 Gordon A. Asher, Chairman of the Special Institute
27 Committee which drew up the brief; and my name is
28 Gilhooly, and I am First Vice President of the
29 Institute.

30 In accordance with the instructions that



1 were given in the preliminary hearing held in Ottawa,
2 and in the interest of brevity, of course, I have no
3 intention of reading the brief, which is a relatively
4 short brief, although it covers quite a lot of ground.
5 The Institute from its very nature covers a wide
6 spectrum of the health interest.

7 In the introductory paragraphs we mention
8 that there are twenty-nine branches across the
9 country and we have forty-three professional groups
10 in Ottawa. As a result of this sort of scattering
11 of the interests of the Institute, our brief probably
12 takes a little different form than many other briefs;
13 we are interested in a lot of matters. But, on
14 the other hand, we are not in a position to document
15 everything that we are going to present in this brief;
16 they represent more the thinking of our members than
17 well-documented cases. It therefore might be
18 helpful if I briefly give to you, which isn't in the
19 brief here, the manner in which the brief was
20 prepared.

21 We were instructed by our Advisory Committee
22 of the Institute to prepare a brief to this Royal
23 Commission, and with this in mind we approached all
24 branches of the Institute and we approached all
25 professions that are represented in the Institute.
26 In the case of all branches we asked them to give
27 us their recommendations or their thinking from a
28 geographical point of view in developments in this
29 area. In regard to the individual professions, we
30 asked them to be general but also to give us their



1 thinking from their own profession, such as nurses,
2 doctors, dentists, in these areas particularly. In
3 the case of nurses, they prepared a brief of their
4 own, which is attached as Exhibits A and B.

5 With this background I will deal briefly
6 with the various points made in the brief.

7 On page 2 there is a summary of the matter
8 that is continued in there. (1) is our submission
9 advocates a greater attention to research and
10 preventive medicine; (2) expresses concern at the
11 rising costs of health services; (3) suggests
12 stricter controls for drug manufacturers; (4)
13 discusses food additives; (5) deals with medical
14 training; (6) is physical fitness; (7) is mental
15 illness; (8) is fluoridization and health education;
16 and (9) recommends advances which should be made
17 in health services provided by the federal government,
18 as an employer, to its own employees. This is
19 the more narrow field of our more direct interest.

20 Now, moving on to the costs of health
21 services, which is the next main heading, I think
22 this summarizes the Institute's general position in
23 regard to the extension of health services in Canada.
24 We recognize the need and desirability of extending
25 and expanding health services as quickly as is
26 reasonably possible. At the same time we appreciate
27 the danger in over-extending and over-taxing the
28 economic capabilities of the nation. Also we feel
29 that there is a need to step carefully in this area
30 and to consolidate our gains before we move to the



1 next stage. This would mean the development of
2 adequate facilities and trained personnel to permit
3 further growth in an orderly manner. We also have
4 a word of caution in regard to waste and loss which
5 might be occasioned because of the rapid technological
6 advance which is going on at the moment, the
7 spectacular breakthroughs which have gone on in
8 recent years, and we draw attention to tubercular
9 control and treatment of poliomyelitis. We think
10 that at this time the greatest overall benefits, and
11 at the least cost, can come through research and
12 preventive medicine. We insert a word here for
13 the consideration of extension of existing health
14 plans in the dental area as rapidly as economics will
15 permit. We become a little more specific before
16 leaving this paragraph -- as I say, this is the main
17 area -- and say that possibly to prevent waste and
18 abuse and overburdening our economic position an
19 immediate step at the moment would be providing
20 health services in what is known as the disaster
21 area. And then we mention that the medical profession
22 must be assured that its function will not become
23 subordinate to systems of administration.

24 Now, the next area in which we deal is
25 drugs, and here we, along with many others, find
26 ourselves disturbed at the high costs of drugs. We
27 consider that the main reason for this is the excessive
28 promotion and advertising expenses, and we also say
29 that steps should be taken to place vitamin pills and
30 food supplements on a prescription basis only. We



1 endorse the recent changes that have been made to
2 regulations which permit the Food and Drug Directorate
3 to exercise greater control over drugs sold in Canada
4 no matter where prepared. This would enable
5 prescriptions to be given more by use of generic
6 names, if we have assurance that the product is up to
7 standard.

8 Now we get into the more narrow areas, as
9 I say, the federal government and its employees. I
10 think here, first of all, we would like to compliment
11 the federal government on the medical plan it now
12 provides for its employees. However, improvements
13 are justified, and I think it is right to say that
14 further improvements made in the plan will be coming
15 into effect very shortly. We think that an early
16 improvement which may be made in the federal government's
17 position with respect to its employees is the
18 introduction of periodic medical examinations. Because
19 of the magnitude of this we limit the thinking on
20 this to possibly biennial examinations for employees
21 over forty years of age, which is quite a sensible
22 area and is in accordance with the practice at the
23 moment. In the same area we would like to see health
24 service units available to federal employees in large
25 urban centres as well as in Ottawa. They are now
26 available in Ottawa, and they have not been expended
27 outside Ottawa.

28 We draw attention to facilities provided
29 by the federal government in the establishments which
30 are not always up to the standards required by



1 provincial laws, and we make mention of one case, a
2 certain establishment in Nova Scotia.

3 The next area in which we deal is the
4 question of food additives. This is a growing area.
5 We all realize, and the Institute feels, that although
6 it is important that we take advantage of all
7 technological advances which can improve and simplify
8 methods of food production without endangering
9 safety, there is a definite need to regulate the
10 flow of new chemical compounds into food supplies.
11 There is also a definite need for increased research
12 to assess the toxic and genetic effects of these
13 additives and residues. We feel that the federal
14 government must take a lead in this.

15 The next area is in medical training. The
16 first thing we mention in connection with medical
17 training is not the establishments themselves but the
18 difficulty for the man in medicine these days to
19 keep abreast of changes in the medical field. We
20 draw attention to a start that has been made in the
21 University of British Columbia in this matter. It is
22 a department of continuing medicine which has been
23 established to keep doctors and allied professions,
24 not only doctors, abreast of developments in the
25 medical field. There is a very great need for
26 medical training facilities, and there is also a
27 very great need to make facilities available to more
28 people. I heard of a friend the other day who spent
29 \$20,000.00 putting his son through medical school,
30 after completing post graduate work. This, of course,



1 is beyond the reach of most of our citizens.

2 The next section here -- I might say it
3 was submitted by the training group of the Institute,
4 and they point to the need of the individual and they
5 point to the need of the educational specialist in
6 medicine, and one of the functions of the educational
7 specialist is to disseminate new material which is
8 becoming available quickly and every day in the
9 medical field, the new techniques and new medicines.
10 This is, of course, to the preventive aspect of
11 medicine.

12 The next paragraph goes on to deal with the
13 need of a specialist in this health field.

14 We draw attention in the next paragraph to
15 physical fitness in Canada. We hope this will not
16 be devoted to sending teams abroad. We hope it will
17 be extended to all Canadians and those who are past
18 the competitive stage for active participation in
19 sports.

20 The next area deals with mental illness,
21 and generally it says more specialists in this area
22 are required, there is a need, and apparently there
23 are some new techniques which are developing in
24 this field which are worth consideration.

25 Fluoridation: The most important need in
26 this area in the opinion of the Institute is placing
27 the full story about this before the public, whatever
28 it may be. There is more heat and not enough light
29 and many conflicting stories. We say fluoridation
30 has been the subject of so many charges and counter-



1 charges that there is a real need for an authoritative
2 statement by the Federal authority to clarify the issues.

3 In the field of provincial medical plans, we
4 have seen the emergence of a medical plan in Saskatchewan
5 in the very near future, and this, of course, is at
6 the heart of the work of the Commission, and we feel
7 there is a very great need for the definition of the
8 federal government's role in the provincial medical
9 plans so that these plans can be evolved across
10 Canada. The first, of course, is on the financial
11 support to provincial plans, and the second is in the
12 framework in which these plans may operate and the
13 extension of existing facilities.

14 Health Education: The Federal government,
15 through its various agencies, can do much to educate
16 the citizens of this country on health problems. Much
17 work is being done in this area, but there is more
18 that could be done. There is a specific recommendation
19 made there that has arisen through our membership, and
20 that is consideration may be given to have all medicine
21 show an expiry date. This can be quite dangerous
22 at times, and the ones that are given in there --
23 Diazone, which evidently becomes stronger as it gets
24 older.

25 Conflicting areas of hospital administration
26 draw attention to the fact that hospitals are ad-
27 ministered by municipalities, provinces, the federal
28 government, religious orders, and even individuals.
29 The lack of uniformity which exists is due to different
30 administration.



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1 On the negative side of health is the cost
2 of dying, which is the last item in the brief, and
3 we deprecate the stress that is currently being
4 put on dying and all the rigmarole which is
5 associated with it.



1 I don't mean disrespect, of course,
2 when I say that. It costs too much to die these days,
3 and I think something might be done in this area. I
4 don't know whether this is within the terms of reference
5 of this Royal Commission.

6 COMMISSIONER BALTZAN: It is just not
7 worth it.

8 MR. GILHOOLY: Yes, that is right.
9 That finishes the main part of the brief.

10 Speaking for the Nurses' Section. I
11 am sure they could speak more adequately themselves,
12 but they have asked me to do it.

13 The brief provides in its first three
14 pages, as requested, of course, in the preliminary
15 statement that was made to this Commission, information
16 on the nurses in the federal service, broken down by
17 departments, by directorates, and by divisions within
18 departments.

19 It also gives a brief description of
20 the functions of each of these units. There are approxi-
21 mately 2,500 nurses in the federal service, which makes
22 the federal service the largest employer of nurses in
23 Canada.

24 For this reason the Federal Government
25 has a very direct interest in the position of the nurses
26 in the community with respect to their salary and their
27 training, and in all these areas. They have a very
28 great interest in the quality of nursing services
29 available.

30 However, the Federal Government is not



1 directly engaged in the training of nurses, except in
2 some areas, where no other facilities are available,
3 and sometimes with regard to special programs.

4 Therefore, from this interest of the
5 Federal Government in the nursing field, and in the
6 calibre of nurses available, the nurses' group have made
7 the recommendation that, and I am reading from page 4:

8 "It is recommended that a more generous,
9 flexible, and at the same time, a
10 basically consistent policy of educa-
11 tional leave be introduced for nurses
12 federally-employed";

13 and they go on to say:

14 "Not only are more bursaries required,
15 but they are needed in a greater
16 variety of levels of academic achieve-
17 ment".

18 They also feel that there is a need for
19 making it possible for promising and experienced nurses,
20 who have proved themselves in government service, to
21 seek further education at the bachelor's, master's and
22 higher levels, and therefore they recommend that considera-
23 tion be given to the provision of a sabbatical year
24 arrangement on salary for selected senior nursing person-
25 nel.

26 Then their brief moves into the area of
27 shortage of nurses, and they admit from the start that
28 the problem of shortages is extremely complex. It is a
29 continuing problem, and there are no simple solutions.

30 However, speaking more narrowly again



1 of the Federal Government as the largest single employer,
2 they feel the Federal Government should develop long-term
3 planning for an improved position, both as to the supply
4 and the calibre of nursing services.

5 They draw attention to the particular
6 need for qualified mental health nurses. Allied with
7 the shortage of nurses is the point made on page 5, at
8 the top, that nurses are still spending valuable time on
9 functions which clerical workers, and other non-nursing
10 personnel could do equally well, or better.

11 They move on to the allied problem of
12 staff turnover, which undoubtedly is related to the
13 question of the salaries of nurses, which have been
14 depressed for some time.

15 In the heading "Job Satisfaction", here
16 there is a problem that is not peculiar to the nurses,
17 but probably is more emphasized there than in other
18 areas. They feel that special recognition should be
19 given to the working nurse, the clinical or bedside nurse
20 in the hospital, and the comparable staff nurse in the
21 public health agency. It is apparent that the road to
22 promotion too often in this field is through the manage-
23 rial or the administrative ladder, rather than in the
24 working area, and a keener appreciation of the strategic
25 nature of the work of a hospital head nurse would go a
26 long way towards achieving optimum utilization of available
27 nursing personnel.

28 They speak, in the next section, again
29 dealing with the shortage of course, of the possibility
30 of recruiting mature young women into nursing. They make



1 reference to the fact that with the earlier marriages
2 these days, many women, after having brought up their
3 families, would still be available in the nursing field.
4 They feel there is a need for more vigorous recruitment
5 of male nurses and it is timely to take a look at the
6 question of nursing assistants.

7 They draw attention to the challenge
8 that is being made right now by the changing nature of
9 the patients in our hospitals. That is the increase in
10 the long-term illness, and our aging population, and they
11 feel that this is an area that requires some study.

12 They emphasize, of course, the need for
13 health examinations. This is allied to the main brief,
14 in order to achieve prevention and early detection of
15 diseases, and therefore this comes to a specific recommen-
16 dation.

17 "It is recommended that the Royal
18 Commission on Health Services give
19 serious thought to the value of regu-
20 lar health examinations, and ways and
21 means whereby they can be made available
22 to many more people of Canada".

23 The last section deals with continuity
24 of care. There is a need here that after you finish
25 your operation, the tendency now is for any further treat-
26 ment to be obtained by the patient himself.

27 There is a need for continuing care of
28 these people, not one short effort and then dropped.

29 Now, from there they move into the
30 conclusions, which basically are a summary of the points



1 that have been made before. I would just like to take
2 issue with one little thing that they say. That nurses
3 are sometimes at fault through not being sufficiently
4 articulate. I think the well-documented and well-presented
5 brief disputes the fact that the nurses are inarticulate,
6 and I would like, in conclusion, to thank the Commis-
7 sioners very much for the opportunity to present this,
8 and their patience in listening to me.

9 THE CHAIRMAN: Thank you, Mr. Gilhooly.
10 Do any of your associates wish to add anything? Any of
11 the nurses? Here is a chance to be articulate.

2 12 MISS PEPPER: Speaking on behalf of the
13 Registered Nurses group of the Professional Institute,
14 I think we are well satisfied with Mr. Gilhooly's inter-
15 pretation of our presentation to the Institute. We have,
16 as you know, presented a brief also to the Glasco
17 Commission, which we would refer to you for further
18 study.

19 I think the writings of both Miss Percy
20 and Miss Smith, who compiled this particular brief to
21 the Health Commission, could be enlarged upon if it is
22 requested.

23 THE CHAIRMAN: Are there any problems
24 special to the northern areas that the nurses would want
25 to discuss?

26 MISS PEPPER: We have the Principal
27 Officer here, Mr. Hall.

28 MISS SMITH: Mr. Hall, geography is the
29 problem. The nursing in the north is very popular. We
30 do not have difficulty filling positions in the north.



1 As a matter of fact, we wish that it was as easy to fill
2 positions in some of the less northerly areas.

3 So as rapidly as facilities are available,
4 as far as nursing is concerned we do not find it diffi-
5 cult to find staff.

6 THE CHAIRMAN: Your area, what area are
7 you covering now, when you speak of the north? Is it
8 the Yukon, Mackenzie, Keewatin?

9 MISS SMITH: Yes, all of the north,
10 all of the Territories, the Mackenzie, the Yukon and the
11 Eastern Arctic, and the Keewatin District.

12 THE CHAIRMAN: What is the situation
13 about the adequacy of the health service facilities
14 there?

15 MISS SMITH: They are increasing
16 rapidly. We are pleased that it has been possible to
17 provide, we believe, very adequate facilities in some
18 areas. There is a five-year plan at the present time,
19 1962 to 1967, which would be, I know, available to you
20 if you wish to see it, and this outlines the plan for
21 the next five years for that area.

22 THE CHAIRMAN: That is a plan in the
23 Department of Northern Affairs, is it?

24 MISS SMITH: Yes, it is Northern Health
25 Services, which acts as the Department of Health, in the
26 same capacity as the Department of Health for Northern
27 Affairs, but this Northern Health is within the Depart-
28 ment of National Health and Welfare.

29 THE CHAIRMAN: I am putting this question
30 because there has been some suggestion as to whether



1 there was an area to be visited by the Commission that
2 we have not been to. We will have covered the ten
3 provinces, but not the Territories.

4 MISS SMITH: I am quite certain that
5 the Department would be most pleased to have you visit
6 any part of the north that you choose to visit. Dr.
7 P.E. Moore is the Director of Medical Services within
8 National Health and Welfare, which administers Northern
9 Health Services.

10 THE CHAIRMAN: Dr. Moore is the person
11 with whom we would get in touch to discuss this five-
12 year plan?

13 MISS SMITH: Yes, and Dr. John Willis,
14 this is his particular responsibility, the Northern
15 Health Service within the medical services.

16 COMMISSIONER BALTZAN: Just one question,
17 Mr. Chairman. I am very much interested in page 4, in
18 paragraph 1; your presentation of the problem of periodic
19 health examinations, and your statement to the effect
20 that perhaps you could suggest a bi-annual examination.

21 Now, this is a fairly large problem,
22 much larger than that, and we are looking for all the
23 information we can get. One speaks of periodic health
24 examinations, and then one asks how extensive an examina-
25 tion a periodic health examination should be. I don't
26 expect you to try to give me the exact answers, but when
27 you are considering that we would like to have some
28 opinions as to what that should embrace. It can be just the
29 simple physical examination, and sometimes it may take
30 you into fairly extensive areas in making the examination.



1 Have you given that aspect some
2 thought? Can you speak of it now?

3 MR. GILHOOLY: I personally haven't
4 given it any thought. I have worked in the civil
5 service all my life, where there are no examinations.
6 I understand they have become quite well-established in
7 the industrial and commercial field, periodic examina-
8 tions, and we speak of the ones that are being used now
9 by Imperial Oil, Metropolitan Life, etc. They must have
10 drawn up pretty carefully what this normally includes.

11 It might have to be trimmed, or enlarged
12 to fit the service.

13 COMMISSIONER BALTZAN: I am thinking in
14 terms of the total population, rather than the employees
15 only, and even not only the 40-year age group. The next
16 question in that same connection always poses the problem
17 of the frequency, and that is as far as we have been
18 able to learn up until now, purely arbitrary. It can be
19 every six months, or it can be up to two years that you
20 say here, and even physicians haven't been able to help
21 us out too much in guiding us and thinking upon the
22 subject because they have been too busy with just, I
23 suppose, thinking in terms of check-up for diseases.

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1 MISS GORDON: Yes, I would like to
2 speak to that point. I am with the civil service
3 health division and we do have there a staff of medical
4 officers who are, in fact, employed in doing physical
5 examinations for federal employees. This is in the
6 Ottawa area and there has been very little laid on so
7 far as to periodic examinations.

8 In a few small groups such as letter
9 carriers and a few others, this is done. In Ottawa,
10 where there is a network of the health units, the
11 nursing council units, there is a plan whereby a new
12 employee has a health appointment with a doctor and she,
13 in turn, screens these people out if they should need to
14 be seen either by their family physician or to the
15 medical centre of this civil service health division.

16 There is a start made in this way.
17 There is a small staff of medical officers, there is a
18 psychiatric consultant and a consultant psychologist but
19 not nearly sufficient to cover a large employee force
20 of about 40,000 here and some 100,000 out across the
21 country so further thought would need to be given to it.

22 COMMISSIONER BALTZAN: I understand
23 these are mainly physical examinations rather than
24 periodic examinations?

25 MISS GORDON: That is true, yes.

26 COMMISSIONER GIRARD: My questions are
27 on nursing and I will direct them to Mr. Gilhooly but
28 he will be free to call on any of the nurses that would
29 wish to answer them.

30 In the brief there is a very short



1 paragraph on nursing and this paragraph pertains mostly
2 to the shortage of nurses and nursing personnel. I also
3 see that this shortage is stressed in Appendix A on
4 page 4 and also Appendix B.

5 Would any one of you wish to enlarge
6 on this question, what you believe are the shortages
7 and what could be the remedies for those shortages?

8 MISS GORDON: Charts were drawn up for
9 Appendix B which shows the nurse in the lowest, as the
10 lowest profession in the remuneration scale in the
11 country.

12 We nurses who happen to be on this
13 delegation are fairly close to the recruitment of nurses
14 for our various services and problems outside the Govern-
15 ment are reflected in our own problems of recruiting,
16 holding staff and, therefore, of stabilizing and main-
17 taining a good quality of service.

18 It is for this reason that we have had
19 to take a very close look at the fact that these people
20 are in the low economic field.

21 We are convinced that some formula will
22 need to be found in the economic structure to correct
23 this. We do not know how this is going to be done
24 because nurses never have, and we hope never will, use
25 the strike weapon either without or within the Federal
26 Government. This remains a problem to us. We are
27 interested in the quality of nursing wherever it happens
28 to be done in the country but more specifically in the
29 Federal Government hospitals and public health nursing
30 services.



1 COMMISSIONER GIRARD: Well, I understand
2 that you have taken this problem up to the Civil Service
3 Commission and something has been done a year ago; from
4 the Appendix B I understand that it has not been done in
5 the right places according to the report but do you feel
6 that this could be taken up again and with some satisfac-
7 tion?

8 MISS GORDON: Representations have been
9 made and we have been given very thoughtful hearings on
10 this problem because I think all are aware it is a
11 problem which concerns us all.

12 The problem at the moment seems to be
13 the policy of the Civil Service Commission of the Federal
14 Government to pay according to good outside employers.

15 Now, this is a good formula when outside
16 employers are paying relatively well but when you apply
17 something that is bad outside to something on the inside
18 you get the same problem in and out. We are still
19 talking about this with various senior officials in the
20 Federal Government.

21 MISS PEPPER: If I may speak, Mr.
22 Chairman: we are quite conscious of the fact that in
23 our presentation and in our negotiations with the Civil
24 Service Commission, you made a specific reference to
25 whether or not we had attained our goals to any degree
26 and whether it was in the right places.

27 We feel this has not been accomplished
28 in that of the some 2,400 nurses we feel the employee,
29 those who were affected by the change of structure,
30 remunerative structure, was confined to about 5%. We



1 are still interested in the nurse who is federally
2 employed and working at the bedside.

3 COMMISSIONER GIRARD: This 5%, you
4 people are in the 5% of the upper bracket so when you
5 are asking for something you are not asking for yourselves
6 but the lower brackets? I gather you are in the upper
7 brackets?

8 MISS PEPPER: We are interested in
9 stabilizing staff and giving good quality and quantitative
10 nursing care and we feel we have not progressed too far.

11 COMMISSIONER McCUTCHEON: Your salaries
12 are in line with salaries paid outside, are they not?

13 MISS GORDON: This is a very hard
14 question to answer. The Pay Research Bureau of the
15 Civil Service Commission is a somewhat new bureau and
16 studies are being made which we think will outline
17 formulae which will really bring in salaries of others
18 with whom we are competing. We are not quite sure, I
19 do not think we are prepared to say with finality, that
20 the group inside the government is across the board in
21 every detail paid as well as the group outside the govern-
22 ment; we are not prepared to make a definite statement on
23 that.

24 We are speaking of the basic nurse, the
25 bedside nurse, the head nurse and, you might go one step
26 higher and say, the first level nursing director of the
27 small hospital and this is a group which compromises
28 around 90% of the whole nursing force and I would say
29 both in and out of government.

30 COMMISSIONER McCUTCHEON: Are you



1 prepared to go in the other direction and say by and
2 large government nurses are paid less?

3 MISS GORDON: I think we would be more
4 prepared to say that but I do not think it is fair to
5 make such a statement. It is difficult to come up with
6 figures to prove it, we only know they are all underpaid.

7 COMMISSIONER McCUTCHEON: That is your
8 whole point?

9 MISS GORDON: Yes.

10 COMMISSIONER McCUTCHEON: The whole
11 nursing profession?

12 MISS GORDON: Yes.

13 MISS PEPPER: The status of the nurse
14 is not being maintained as compared to the status of
15 other professions. Persons on the health team with whom
16 we work, social workers and dietitians and so on, we
17 want to attain the status of our co-workers.

18 THE CHAIRMAN: Well now, nurses are
19 employed, some in industrial plants but by and large in
20 hospitals. Do you accept that? Of course, there are
21 private nurses who are doing private duty nursing.

22 MISS PEPPER: More and more the employ-
23 ment of the nurse in the public health field is expanding.

24 THE CHAIRMAN: That is governmental?

25 MISS PEPPER: Well, civil or municipal,
26 yes.

27 THE CHAIRMAN: And hospitals?

28 MISS PEPPER: Yes.

29 THE CHAIRMAN: The Federal Government
30 is the largest single employer ---



1 MISS PEPPER: I think I would be correct
2 in saying that the hospital field is where the most
3 nursing service is centralized.

4 THE CHAIRMAN: And I suppose that that
5 is the place where the salary standard is becoming fixed
6 or bogged down?

7 MISS PEPPER: That is quite right.

8 MISS GORDON: The Department of Veterans'
9 Affairs employs about 1,700 nurses and the Department
10 of National Health, the other 700 or so.

11 THE CHAIRMAN: Apart from the federal
12 services altogether, the hundreds of hospitals across
13 the country, your complaint is that the salary schedule
14 there is too low?

15 MISS PEPPER: That is right.

16 THE CHAIRMAN: And that any increase
17 there is immediately reflected in the operation of
18 hospitals and the cost of hospital operation?

19 MISS PEPPER: That is it.

20 THE CHAIRMAN: So that we are right back
21 to the question of the cost of health services?

22 MR. GILHOOLY: This probably leads back
23 to the section of the brief dealing with the possibility
24 of substituting other workers for nurses in clerical work
25 and employment of nursing assistants.

26 THE CHAIRMAN: Are you speaking now in
27 government service?

28 MR. GILHOOLY: No, I am speaking
29 generally.

30 THE CHAIRMAN: In hospitals?



1 MR. GILHOOLY: Yes.

2 THE CHAIRMAN: And doctors' offices
3 and dentists' offices?

4 MR. GILHOOLY: As receptionists
5 instead of nurses, this point is made in the brief of
6 the nurses themselves.

7 MISS GORDON: It is better utilization
8 of nurses.

9 THE CHAIRMAN: No longer used so much
10 as airline hostesses?

11 MR. GILHOOLY: That is an excellent
12 example.

13 MISS PEPPER: They have entirely with-
14 drawn from that field, of course.

15 COMMISSIONER GIRARD: On page 4 of the
16 Appendix A there are two recommendations, one deals with
17 the consideration of provisions of a sabbatical leave
18 with salary. Would the sabbatical leave be given only
19 for the pursuing of studies or would it be a sabbatical
20 leave with salary for any purpose?

21 MISS GORDON: I believe the thought
22 behind this was for any approved purpose.

23 COMMISSIONER GIRARD: Any approved
24 purpose?

25 MISS SMITH: Yes.

26 COMMISSIONER GIRARD: So it would not
27 be given as a routine?

28 MISS SMITH: At this stage of our
29 thinking I do not think so. I may not be right in this
30 because this was contributed by someone other than



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1 myself but it was thought that, as it is stated in the
2 original brief, the idea of permitting a nurse to get
3 away, either study or travel or do what might be done
4 to enrich her life in other ways and she would come back
5 fresher to her work having had this time because we do
6 know, as in other professions, every day is so full of
7 work itself.

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1 COMMISSIONER GIRARD: Yes. I also know in
2 some of the Scandinavian countries nurses have to every
3 five years take a refresher course at the expense of
4 the Government. You probably heard about that at
5 some of our meetings. Then this sabbatical leave you
6 were advocating as a sabbatical leave would be given
7 with no strings attached but you would hope that the
8 nurse would use the sabbatical leave to get further
9 education or refresher course or something that would
10 bring back -- where she could bring back some
11 experience to her work.

12 MISS SMITH: I believe that is right.

13 THE CHAIRMAN: Is not the whole idea of the
14 sabbatical leave that time will be spent in improvements?

15 MISS SMITH: Yes, that is right, I am sure
16 of that, but it just is how; whether they have a formal
17 course of study or travelled observation. It would be
18 decided upon according to the need of the individual
19 people who are going.

20 THE CHAIRMAN: You couldn't just leave it to
21 the individual. It has to be fairly rigid. All
22 sabbatical arrangements that I have heard of are pretty
23 well laid out, not just a holiday.

24 MISS SMITH: No, it would be approved by the
25 organization. The employer.

26 COMMISSIONER GIRARD: On page 5 there is a
27 question of utilization there. You think so, and we
28 do know Canadian nurses association are doing some
29 studies and have some projects on that, I won't dwell on
30 it. Under paragraph 2, job satisfaction, in the second



1 part of this paragraph it is stated:

2 "A change in attitude together
3 with a keener appreciation of the
4 strategic nature of the work of
5 the hospital head nurse would go
6 a long way towards achieving
7 optimum utilization of available
8 nursing personnel."

9 When you say "a keener appreciation" of the
10 head nurse's position, could you define this a little
11 bit more? In what ways can we show the head nurse
12 -- I am not referring to salaries just now -- in what
13 ways can we show the head nurse a keener appreciation
14 of her position, of her strategic position on the team?

15 MISS SMITH: We in addition to thorough staff
16 educational program to help her to get ready for her
17 job, her appointment, we would hope our head nurse
18 would have a minimum of one year of graduate work in
19 hospital nursing service administration.

20 COMMISSIONER GIRARD: Are you advocating
21 scholarships for this?

22 MISS SMITH: Yes.

23 COMMISSIONER GIRARD: You are. This is
24 along the line a lot of people are thinking. Now you
25 do mention also married women. Is there anything in
26 the employment clauses of married women in the civil
27 service that would bar them from some of the benefits
28 or that would not make them capable of being employed
29 under the same conditions as unmarried nurses?

30 MISS GORDON: No.



1 COMMISSIONER GIRARD: No, there is no
2 discrimination against married women in the civil
3 service?

4 MISS GORDON: There was at one time but that
5 has been completely relaxed.

6 COMMISSIONER GIRARD: Your point in bringing
7 this up here is that there should be a more vigorous
8 recruitment program for married nurses?

9 MISS SMITH: Yes.

10 COMMISSIONER GIRARD: This is the only point
11 you want to make regarding the married nurse?

12 MISS SMITH: Yes. Very often in
13 interpretation, the married nurse taking the trouble to
14 help her to learn how she might work it into her life
15 and yet not give up the family really is part of it.

16 COMMISSIONER GIRARD: I think the nursing
17 profession depends largely on married nurses these days.
18 I know in the hospitals we do, very very much. Anything
19 that we can do to bring back married nurses to the
20 profession would be very helpful.

21 There is one more paragraph here, male nurses
22 and there is a sentence, the last sentence says:

23 "The preparation of so few
24 in our schools of nursing would
25 appear to be short-sighted policy."

26 Well I don't know why it is stated that way because if
27 I speak for myself, for one, I think we do want male
28 nurses very much in the schools of nursing. I have
29 been trying very hard to get some in our own school
30 and I know that other directors of nursing are doing



1 the same so I don't know where this short sightedness
2 comes from. I think I would rather explore why we
3 are not getting male nurses. What are the conditions
4 that are keeping them out?

5 THE CHAIRMAN: Possibly the salary range
6 certainly must have a precise bearing on it.

7 COMMISSIONER GIRARD: Do you know of any other
8 reasons? Do you know of any reasons where nurses would
9 not want male nurses to come in the profession?

10 MISS PEPPER: Perhaps it is that we have not
11 made this a particular factor in our recruitment
12 campaign and in our public relations and in trying to
13 induce men to come into the profession. Certainly
14 have no barriers to keeping them out.

15 COMMISSIONER GIRARD: Except, of course, the
16 salary. This has been, I think, in the last decade
17 a barrier because a male nurse has to think of
18 supporting a wife and family and he probably couldn't.
19 Outside of that there is no discrimination that you
20 know of is there against having male nurses come into
21 the schools of nursing?

22 COMMISSIONER STRACHAN: Are there any residences
23 for them?

24 MISS PEPPER: I would say sir residences are
25 disappearing.

26 COMMISSIONER GIRARD: You believe this also
27 is a question of a vigorous recruitment program?

28 MISS PEPPER: I would think that is specifically
29 referred to.

30 MISS GORDON: And make it attractive economically.



1 COMMISSIONER GIRARD: Make it possible for a
2 male nurse to come in the profession and support a
3 family?

4 MISS GORDON: To do this and have a family.

5 MISS SMITH: Mr. Chairman may I say perhaps
6 the term "shortsighted" was an unfortunate one and
7 certainly does not apply to our most progressive
8 directors of nursing and principals of schools of
9 nursing. Perhaps some of us have lived through a time
10 in Canada when the male nurse was not quite as
11 acceptable as he is today and perhaps we still have
12 people in administration and educational positions
13 who do not quite understand the need for attracting
14 as many men as possible. I think this could be said
15 fairly.

16 COMMISSIONER GIRARD: I am sure Miss Smith
17 in your work that you do see a lot of areas where male
18 nurses would be tremendously important. Where they could
19 be a great help?

20 MISS SMITH: Yes indeed. We always have --
21 I think we have about fourteen at the present time.

22 COMMISSIONER GIRARD: You do have fourteen
23 male nurses now?

24 MISS SMITH: Yes.

25 COMMISSIONER GIRARD: Would you employ a
26 lot more if you could get them?

27 MISS SMITH: Yes, we would.

28 COMMISSIONER GIRARD: Thank you very much Miss
29 Smith.

30 COMMISSIONER STRACHAN: Referring to page 4,



1 the first sentence of paragraph 2, you state, "The
2 professional institute wishes to compliment the
3 Federal Government on the medical plan now provided
4 for its employees, and on the improvements made to
5 it". Then in the first sentence of paragraph 2 "For
6 the same reason the health service units available to
7 federal employees in Ottawa should be extended..." etc.
8 Now are you talking about two different situations
9 there? I am not quite clear on the meaning. Does
10 the first cover all employees of the Federal Government
11 and then there seems to be a limitation of those who
12 are in Ottawa.

13 MR. GILHOOLY: We are referring to two different
14 matters there. The first is briefly known as the
15 group surgical medical insurance plan for Federal
16 public servants which has been in effect for a number
17 of years. This is an insurance type of plan.
18 Indemnity plan.

19 COMMISSIONER STRACHAN: Available to all
20 employees across Canada?

21 MR. GILHOOLY: That is right exclusive of
22 certain areas such as Crown companies who in many cases
23 have their own but generally available to all Federal
24 public servants. This is a usual type of insurance
25 plan to which civil servants contribute approximately half
26 the contribution and the Federal Government contributes
27 the other half. Now the reference there in the first
28 sentence is solely to that plan. The second is to a
29 different matter entirely.

30 COMMISSIONER STRACHAN: And referring to if the



1 federal employee moves away from Ottawa this service
2 is no longer available to him. Is that it?

3 MR. GILHOOLY: Well in the second paragraph
4 there are available health service units in Ottawa.
5 There are a number of them. I couldn't say how many.
6 Possibly somebody else at the table could. These are
7 peculiar to Ottawa. There are no service health units
8 outside Ottawa.

9 Take an area like Toronto. I think we have
10 something like 30,000 civil servants in Toronto but
11 there are no civil service health units. These are staffed
12 with nurses and a modest amount of equipment but these are
13 only available in the City of Ottawa, not outside. Even
14 though places like Toronto may have as high as 30,000 civil
15 servants, there are no health units.

16 COMMISSIONER STRACHAN: Of what do these
17 units comprise? Why are they usually centred in Ottawa?
18 Can they not be established elsewhere?

19 MR. GILHOOLY: Miss Gordon could probably inform
20 you much better than I.

21 MISS GORDON: These so-called health units
22 are nursing units staffed by public health nurses and
23 they are in most of the large government buildings in
24 Ottawa. These were set up shortly after the war and the
25 long range -- they are part of the civil service health
26 division that has been mentioned earlier.

27 The long range plan, when the service was set up,
28 was that these -- in fact when the Act set up the Department
29 of National Health and Welfare it called for extension of
30 such nursing units to all other cities in Canada where there



1 are large concentrations of federal employees but to date
2 this has not happened.

3 Cabinet approval, I believe, has not yet
4 been obtained for this expansion so that the service has
5 grown up in Ottawa to the extent that there is
6 almost complete coverage of this kind to the Federal
7 employees here and these nurses give the kind of
8 first aid and emergency service that an industrial
9 nurse would give but in addition, and since they are
10 qualified public health nurses, they given a preventive
11 service and health teaching, counselling service and
12 their job is to keep the employee on the job; to
13 reduce sickness and absenteeism and to in any way
14 possible enhance the quality of the service which the
15 employee gives.

16 COMMISSIONER STRACHAN: How long has this
17 been on the Statute and is it still dependent upon the
18 will of the Government and the Cabinet?

19 MISS GORDON: I understand it is sir. It
20 has been on the Statute since the Department of National
21 Health and Welfare was set up in 1945.

22 COMMISSIONER STRACHAN: Is there no action
23 on the part of the employees outside of Ottawa to have
24 these units established?

25 MISS GORDON: Yes, there has been considerable
26 action. There have been many requests to the various
27 employee Associations, such as the Professional
28 Institute and others. There have been repeated requests.

29 COMMISSIONER STRACHAN: Thank you. Coming
30 to another subject, Mr. Gilhooly, the fact that the
Institute has mentioned fluoridation should indicate



1 to us that you have made a study of this subject, and
2 if so, you must be aware of the report of the Morden
3 Commission. What in your opinion would be, in your own
4 words, the true story regarding fluoridation?

5 MR. GILHOOLY: Well first of all, I must --

6 COMMISSIONER STRACHAN: Or is this a case
7 of the Institute sitting on the fence?

8 MR. GILHOOLY: First of all I must say that
9 the Institute has not studied the subject of fluoridation
10 and I venture to say the best position for the Institute
11 in this matter is on the fence. We represent 6,000
12 employees and we probably have 3,000 split sides, just
13 the way the country seems to be split so possibly
14 on the fence is our best position until we get an
15 authoritative statement in this area.

16 COMMISSIONER STRACHAN: Who is going to issue
17 this authoritative statement to satisfy your thousands
18 of members?
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1 MR. GILHOOLY: Well, the thing is, in
2 my opinion - I must speak in my own personal opinion
3 here - it seems to me that all statements I have seen
4 with regard to fluoridation are from interested parties.
5 On one side, the dentists and doctors, and on the other
6 side we have various champions of civil rights.

7 COMMISSIONER STRACHAN: You say the
8 interests of the medical profession and dentists. What
9 is your interpretation of those interests?

10 MR. GILHOOLY: Strongly for fluoridation,
11 from what I read. But people on the other side, of
12 which there are many different groups, are strongly
13 against.

14 COMMISSIONER STRACHAN: And I repeat,
15 you must be aware of the report of the Morden Commission.
16 You still consider that not a true story of the fluorida-
17 tion issue, or why would you mention it at all?

18 MR. GILHOOLY: Well, I do personally,
19 but there are many of my people that I know who don't.
20 Now, rightly or wrongly, I don't know, but we have not
21 had - the Morden Commission was an Ontario Commission?

22 COMMISSIONER STRACHAN: Yes.

23 MR. GILHOOLY: We have not had a federal
24 statement on it, which is what we are referring to here,
25 which may carry authority.

26 COMMISSIONER STRACHAN: With respect to
27 the federal research, the recent federal research, may
28 I ask you to what you refer there?

29 MR. GILHCOLY: I am sorry, what page is
30 that on?



1 COMMISSIONER STRACHAN: Page 7.

2 MR. GILHOOLY: Mr. Asher informs me
3 that our members have in turn informed us that there
4 has been considerable research done in this field by
5 the federal employees which has not yet been published.

6 COMMISSIONER STRACHAN: What are you
7 referring to? What is the research you are referring
8 to? I am thinking of one thing on which there are a
9 considerable number of publications from year to year.
10 I don't know whether it is the same thing or not. What
11 is the research that you refer to?

12 MR. ASHER: I think that most of this
13 research that is published is published in scientific
14 journals and there is not enough of it interpreted for
15 the layman so that he can understand the developments
16 that are taking place.

17 COMMISSIONER STRACHAN: What research
18 are you referring to?

19 MR. ASHER: Well, unfortunately I don't
20 have exact details of the research going on. We were
21 informed by our members that there was considerable
22 research being done by the Federal Government in this
23 field, but it has not been generally available to the
24 public except through scientific publications.

25 COMMISSIONER STRACHAN: I am thinking
26 of the study made in the Brantford, Sarnia, Stratford
27 areas, and I would be very surprised if that information
28 is not available from the Department of Health and
29 Welfare to anyone who would care to write for it, and
30 I don't know how they could put it in simpler terms



1 other than the fact that they do use three letters, D,
2 M and F, which mean decay, missing and filling.

3 MR. ASHER: I think that is the problem,
4 you might have to write for it. We feel there should be
5 more general information available about it, not that
6 you should write to the right address and pay for it.

7 COMMISSIONER STRACHAN: Then we can
8 only come back to the fault of the civil service that
9 they don't do this.

10 THE CHAIRMAN: It is not our purpose
11 to make insinuations to groups before us.

12 MR. GILHOOLY: I think the point there
13 is that it is quite evident that there is confusion in
14 the mind of the general public. Votes taken in recent
15 years in this area indicate that it is not clear-cut,
16 and all this paragraph says is that the Federal Govern-
17 ment should take the lead in respect to fluoridation and
18 put it fairly and accurately in front of the people of
19 Canada so that we can have an informed electorate on
20 the subject.

21 COMMISSIONER STRACHAN: You feel that
22 if three men were appointed by the Federal Government
23 and went over the same material and no doubt faced the
24 same individuals as the Morden Commission they would
25 no doubt come up with anything different than the Morden
26 Commission, just because they had a federal stamp on it?

27 MR. GILHOOLY: No, I am not saying
28 they would come up with any different conclusions, but
29 I am saying that their conclusions should be placed in
30 front of the electorate so they can vote for or against



1 fluoridation. I don't think this paragraph intends to
2 question the research or investigation, it certainly
3 doesn't question the results of the investigation, but
4 it says that the ---

5 COMMISSIONER STRACHAN: The Morden
6 Commission does not suggest that.

7 MR. GILHOOLY: I didn't suggest it
8 personally, but it is such a political hot potato at
9 the municipal level that you will have to have an
10 informed electorate.

11 MR. ASHER: There is no question that
12 it has been submitted to the electorate. It was
13 submitted in Edmonton recently.

14 COMMISSIONER STRACHAN: The Morden
15 Commission suggested it need not be and shouldn't.
16 Thank you, Mr. Chairman.

17 COMMISSIONER VAN WART: On page 6, you
18 speak of educational specialist and outline what his
19 duties are. Have you any educational specialists
20 working at the present time?

21 MR. GILHOOLY: Do you mean on this
22 Committee or in the Government generally?

23 COMMISSIONER VAN WART: You suggest
24 that the educational specialist is needed in preventive
25 health services programs. Are there any specialists
26 working at the present time along the program that you
27 suggest?

28 MR. ASHER: This was submitted by our
29 educational group, and unfortunately we don't have a
30 representative here. I can't answer that fully. I don't



1 think there is a great deal being done from the informa-
2 tion we received at the time this was being prepared.

3 COMMISSIONER VAN WART: These indivi-
4 duals evidently need special training in their sphere
5 of action. Do you know if such courses are available
6 at the present time?

7 MR. ASHER: I cannot answer that with
8 certainty. I believe that some of it is available at
9 the University of Toronto; it was mentioned once to me
10 in this connection. Unfortunately, I cannot give you
11 any further details.

12 COMMISSIONER VAN WART: Coming to the
13 nursing, in Appendix A you mention 2,500 nurses in the
14 civil service and 500 in the army, which makes about
15 3,000 nurses altogether, and on page 3 you mention the
16 fact that the Federal Government is not directly engaged
17 in the basic preparation of nurses except in a few
18 small areas. Do I infer from this that you think that
19 the Federal Government should participate in the educa-
20 tion of nursing?

21 MISS SMITH: No, not about the provision
22 of a School of Nursing about that. As mentioned with
23 reference to the health grants, participation and support
24 and financial aspect is, we feel, justified and needed.

25 The educational bodies that we want to
26 look after the education of nurses ---

27 COMMISSIONER VAN WART: In other words,
28 you feel that there should be further financial support
29 from the Federal Government in training, in the basic
30 training of nurses?



1 MISS SMITH: We have not made that
2 statement in our brief. We have commended the grants
3 in aid as far as they have gone; and when you say basic
4 education for nurses, our mention has been for advancing
5 the preparation for specific work in government of
6 employees by more liberal bursary program, and so forth.

7 COMMISSIONER VAN WART: Post-graduate
8 training, so to speak?

9 MISS SMITH: Yes.

10 COMMISSIONER VAN WART: But where the
11 Federal Government employs 3,000 nurses, and also if
12 industry employs a large number of nurses, does it seem
13 right that they make some contribution towards the basic
14 training of these nurses, where they are utilizing them
15 and their services?

16 MISS SMITH: It is through the grants
17 in aid that this has been done because of the B.N.A.
18 Act. It is to provinces.

19 COMMISSIONER VAN WART: Grants in aid
20 are made for nursing purposes or for public health
21 nurses only?

22 MISS SMITH: No, it is for public
23 health, training in the health field, not only nurses.

24 COMMISSIONER VAN WART: That is a
25 graduate field, it is the under-graduate basic training.
26 There are no grants in aid for that, are there?

27 MISS SMITH: I prefer not to speak to
28 this. But I do believe that some of the funds that are
29 provided through the grants in aid to the provinces do
30 assist under-graduate students through the particular



1 range in that province. I have no further information
2 at this time.

3 COMMISSIONER VAN WART: You think an
4 enlargement of that program is desirable?

5 MISS SMITH: We believe that education
6 of nurses requires further public support in order that
7 the education provided will produce the type of nurse
8 that we require in sufficient numbers.

9 COMMISSIONER VAN WART: Are you having
10 any difficulty in recruitment for your federal nursing
11 services?

12 MISS PEPPER: We have had specific
13 difficulty in certain areas, specifically in some of
14 our Veterans' Affairs Hospitals, especially because -
15 at least, this is our interpretation of the problem -
16 because of the longevity aspect, our patients, perhaps
17 nursing is not as spectacular, appealing.

18 In most of our Veterans' Affairs
19 Hospitals recruitment has been low for a considerable
20 length of time.

21 COMMISSIONER McCUTCHEON: That is shown
22 on your chart?

23 MISS PEPPER: Yes.

24 COMMISSIONER VAN WART: Is there a
25 field for nursing assistants? Is there a field for them?

26 MISS SMITH: Yes, in our hospitals
27 approximately 45% of the positions are for nursing assis-
28 tant classification.

29 COMMISSIONER VAN WART: That would be
30 in addition to the 3,000 that you speak of?



1 MISS SMITH: Yes, definitely.

2 COMMISSIONER VAN WART: And they are
3 entirely trained by federal grants, are they not?

4 MISS SMITH: No. There are different
5 arrangements in each province, and in the Province of
6 Ontario it is the Provincial Government in collaboration
7 with the Registered Nurses' Association which operates
8 the schools for nursing assistants.

9 COMMISSIONER VAN WART: Is it through
10 the Department of Education and provincial governments
11 associated with the Unemployment Insurance of Ottawa
12 that the schools are set up? I know in our province
13 that is the way they are set up. Is that not true in
14 other provinces?

15 MISS PEPPER: There is a variation from
16 province to province. Now, I am cognizant of the fact
17 that the Department of Veterans' Affairs conducts
18 certain schools in various areas across Canada. It is
19 variable.

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1 MISS GORDON: And there is a movement on
2 foot for various hospitals to conduct their own setup
3 and training programs, but there are areas in which
4 the Department of Labour, and the educational aspect
5 enters in.

6 COMMISSIONER VAN WART: There is no avenue
7 by which nursing assistants in the public service can
8 be promoted, or obtain registered nurse status is there?

9 MISS GORDON: No, there is no such plan
10 anywhere in Canada where this can be done sir. I
11 think that nurses, both inside and outside of the
12 federal government, are looking at this whole question
13 very seriously, as to whether the nursing assistant
14 movement has not got a bit out of hand, and possibly
15 have been pushed into areas where they are not equipped
16 to give the service that they are asked to give.

17 COMMISSIONER FIRESTONE: Mr. Chairman, Mr.
18 Gilhooly if I may turn to the second last paragraph
19 on page 2, you say, and I quote:

20 "Whenever economic conditions warr-
21 ant further expansion to existing
22 health plans, then dental care
23 should be considered as a part of
24 general medical care."

25 Would this mean that if the federal government were
26 to offer financial grants to provinces to introduce a
27 medical care plan in the respective provinces, then
28 a similar plan should be developed in the field of
29 dental care. Is that what your recommendation entails,
30 or the suggestion entails?



1 MR. GILHOOLY: I don't think I could become
2 quite as specific as that.

3 COMMISSIONER FIRESTONE: I quite agree.

4 MR. GILHOOLY: This merely says that in
5 considering further steps in the medical field, or
6 the field of medical care, the field of dental care
7 should also be kept in mind, and when economic
8 conditions warrant steps in this area, they should be
9 made. How they should be made I don't know quite
10 frankly, and the brief does not try to show.

11 COMMISSIONER FIRESTONE: You are quite right.
12 You have made the general statement. We are just
13 trying to understand how the general statement can
14 be applied. Does it mean that if such a recommendation
15 were adopted, that something should be done in the
16 field of dental care if we are to proceed along the
17 lines of your proposal in the second last paragraph?

18 MR. GILHOOLY: The answer to that is a flat
19 yes, subject to the qualification that we can economically
20 afford it.

21 COMMISSIONER FIRESTONE: Thank you very much.
22 May we now turn to page 3, the third paragraph, and I
23 quote:

24 "The Professional Institute is
25 also disturbed by the high cost of
26 drugs."

27 -- and then you proceed on to suggest certain measures
28 that might be taken to deal with the problem, which
29 you claim exists in Canada. One such suggestion is,
30 and I quote:



1 "This could be done by placing
2 limits on deductions attributable
3 to such charges as legitimate
4 business expense."

5 Do you have in mind a provision which, for example,
6 would provide that not more than X per cent of the
7 cost of drugs, or the manufacturer's sale price, would
8 be allowable expense for promotional and advertising
9 purposes, and anything beyond that would not be
10 allowed?

11 MR. GILHOOLY: That is right.

12 COMMISSIONER McCUTCHEON: Do you make the
13 same suggestion with respect to soap manufacturers,
14 and breakfast food manufacturers? They are connected
15 with health.

16 MR. GILHOOLY: I presume when we establish
17 a Royal Commission on Soap we would make it there too.

18 COMMISSIONER FIRESTONE: You are saying it
19 because you are concerned with the high price of drugs,
20 and you look on drugs as essential to health?

21 MR. GILHOOLY: Yes.

22 COMMISSIONER FIRESTONE: In paragraph 4 on
23 page 3:

24 "Steps should also be taken to
25 place vitamin pills and food
26 supplements on a prescription basis
27 only".

28 Is there a country where such practice is in operation
29 that you know of?

30 MR. GILHOOLY: I don't know of any. I don't



1 say there is not, I don't know of any, no. This
2 follows very logically I think from the recent
3 statement of Dr. Monagle, which was quite a sweeping
4 denunciation of the whole area of vitamin pills and
5 food supplements, and there is evidence in that
6 statement that there is need for steps in that area.

7 COMMISSIONER FIRESTONE: This is an area
8 where you think there is a need for steps in view of
9 the statement of an expert in this field. Do you
10 think this would meet the needs of the people?

11 MR. GILHOOLY: I have no views.

12 COMMISSIONER FIRESTONE: The next question
13 relates to the third paragraph on page 5. You say
14 that you recommend, and I quote:

15 "A planned program for
16 continuing medical education."

17 What would you say in your opinion would be the
18 essential features of such a planned program?

19 MR. GILHOOLY: I wouldn't attempt to give them,
20 Dr. Firestone, because I am not knowledgeable in this
21 area, but I do draw your attention to the fact that
22 there has been such a program developed in the
23 University of British Columbia. I have no method of
24 assessing it.

25 COMMISSIONER FIRESTONE: You would feel that
26 this Commission should examine the U.B.C. program, and
27 if we find it acceptable, it should form the basis of
28 such a proposal as you envisage at that paragraph?

29 MR. GILHOOLY: I think I will be more general,
30 and I did apologize for being general when I first



1 started presenting the brief, saying that there is a
2 need for a means of disseminating the advances that
3 take place among the medical profession, and I am
4 speaking not only of doctors, but right down through
5 the whole medical field, and we draw attention to the
6 fact the University of British Columbia has taken
7 steps in this area, and it might be useful to
8 consider it.

9 COMMISSIONER FIRESTONE: Do you envisage
10 financial assistance from the federal government in
11 such a planned program for continuing medical education?

12 MR. GILHOOLY: I would think so, but it does
13 not necessarily have to be. It might be just a lead
14 in it that might be possible, but it would probably
15 develop that financial assistance from the federal
16 government would be necessary, but we are dealing with
17 a provincial area here, the area of education.

18 COMMISSIONER FIRESTONE: You would like to
19 give this thing a push, and presumably some incentives
20 might help?

21 MR. GILHOOLY: Yes, a recommendation from
22 this Royal Commission that there is a need might trigger
23 it in the provinces. This might be wishful thinking,
24 without federal aid.

25 COMMISSIONER FIRESTONE: Would you turn now
26 to page 7, the third paragraph, and I quote:

27 "Steps should be taken to
28 adjust these contributions, in
29 order that all provinces can
30 provide comparable levels of health



1 benefits to its residents".

2 You are talking in this paragraph about federal
3 financial assistance to the provinces?

4 MR. GILHOOLY: That is right.

5 COMMISSIONER FIRESTONE: Could you explain
6 to the Commission what you mean by the phrase adjust?

7 MR. GILHOOLY: Well, we have a basic problem
8 in Canada because of the various levels of average
9 income that exist among the various provinces. We
10 have what is commonly called our have and our have
11 not provinces, and our wealthy and our less wealthy
12 provinces. The thought here is that in any federal
13 contribution to a provincial medical plan, the
14 contribution should be scaled in such a way as to
15 assist, shall I call the have not provinces for the
16 want of a better word or the less wealthy provinces,
17 to give a fairly uniform medical health service
18 across Canada.

19 COMMISSIONER FIRESTONE: You are envisaging
20 a given standard of medical care all across the
21 country?

22 MR. GILHOOLY: That is the thought, yes.

23 COMMISSIONER FIRESTONE: And that if some
24 of the provinces cannot afford, with their limited
25 revenues, to finance such a plan, they should be
26 receiving a proportionately higher payment, whether
27 it is per capita or some other formula, than the
28 wealthier provinces?

29 MR. GILHOOLY: That is right.

30 COMMISSIONER FIRESTONE: In other words, you



1 are envisaging something which may be called
2 equalization payments in the field of health services?

3 MR. GILHOOLY: That is right.

4 COMMISSIONER FIRESTONE: And I take it these
5 equalization payments would be based on the financial
6 ability of the provinces?

7 MR. GILHOOLY: Yes.

8 COMMISSIONER FIRESTONE: My last question
9 refers to paragraph 14 on page 8, which is the
10 third paragraph on that page. You say that in the
11 field of hospital administration there is a great
12 diversity of administration, and great variation, and
13 you comment on the lack of uniformity in training and
14 in administration, etc. You suggest that this is
15 one aspect that needs extensive investigation. Now,
16 have you any suggestions how we in Canada can cope
17 with this problem of lack of uniformity and lack of
18 minimum standards? What can be done, and in particular
19 I would like you to remember that you are offering
20 advice here to a Royal Commission, which is expected
21 to offer advice to the federal government, therefore the
22 question before you is what can the federal government
23 do to achieve greater uniformity of administration, etc.
24 in the hospital field?

25 MR. GILHOOLY: I don't want to speak too
26 freely in an area where I don't know too much, but I
27 understand that steps have already been taken with
28 the implementation of the provincial hospital schemes
29 to bring hospitals up to certain minimum standards
30 in order to qualify for payments under the federal



1 payments to the hospitals. This, of course, is a
2 step in this direction, but I had better not go too
3 far. I must say I know very little about this. It
4 is not my area of operations. I am parroting to a
5 certain extent what has come up to us in this area.

6 MR. ASHER: I would like to suggest it might
7 be a condition of the grants and aid that are now being
8 made to the provinces that certain standards be met.

9 COMMISSIONER FIRESTONE: Would such standards
10 include a provision that certain minimum rates of
11 pay be paid to health personnel employed in hospitals
12 across the country?

13 MR. ASHER: I wouldn't wish to comment about
14 that.

15 MR. GILHOOLY: Didn't we recently have
16 something about maximum rates? If we go into maximum
17 rates we could go into minimum rates.

18 COMMISSIONER FIRESTONE: In your opinion this
19 would be one of the minimum standards that you would
20 envisage?

21 MR. GILHOOLY: Yes, I would think so.

22 COMMISSIONER McCUTCHEON: How popular do
23 you think that would be with the provinces?

24 MR. GILHOOLY: Well, if we adopt the whole
25 spectrum of graduated scales of contributions to
26 the provinces in hospital and possibly dental fields,
27 they should be able to afford minimum rates in time.

28 COMMISSIONER STRACHAN: You made mention
29 of the interest of the medical and dental profession.
30 I would trust that you have no reference to self-



1 interest of the health professions, because they have
2 absolutely no self-interest in the matter of
3 fluoridation. It is purely in the interests of the
4 public in general, the children in particular, and
5 more particularly the children yet unborn. If you
6 will agree with me?

7 MR. GILHOOLY: I am glad you said that,
8 because I heartily endorse what you are saying. This
9 is very true, and it sometimes puzzles me that there
10 is an altruistic position in this area.

11 COMMISSIONER STRACHAN: To end on a lighter
12 vein, I sometimes think that the anti-fluoridationist
13 is like the man on the street who is against fluor-
14 idation of water supplies because he was absolutely
15 certain it would be too expensive to bring water
16 from Florida.

17 THE CHAIRMAN: Thank you very much, Mr.
18 Gilhooly. You will appreciate from the discussion
19 that we place a lot of value on the views of the
20 Professional Institute of the Public Service of
21 Canada and we want to thank you for the trouble you
22 went to in the preparation of the brief, you and your
23 associates and the nursing section as well.

24 MR. GILHOOLY: Thank you very much.

25 THE CHAIRMAN: We will rise and resume at
26 10:00 o'clock tomorrow morning.

27 ---Adjourned.
28
29
30

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

OTTAWA

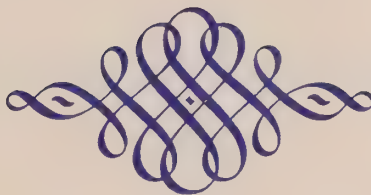
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4 ROYAL COMMISSION ON HEALTH SERVICES

5 Proceedings of the hearing held
6 in Ottawa, Ontario, on the 22nd
7 day of March, 1962.

8 COMMISSION MEMBERS:

9 Chief Justice EMMETT M. HALL -- Chairman

10 Miss ALICE GIRARD, R.N.

11 Dr. C.L. STRACHAN

12 Dr. ARTHUR F. VAN WART

13 Mr. M. WALLACE McCUTCHEON, Q.C.

14 Prof. O.J. FIRESTONE

15 Dr. DAVID M. BALTZAN

16
17 COMMISSION COUNSEL:

18 Mr. R.N. HALL, Q.C.

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20 COMMISSION SECRETARY:

21 Mr. N. LAFRANCE
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ASSOCIATION 7320

THE CANADIAN TUBERCULOSIS
ASSOCIATION 7330

THE GREAT-WEST LIFE ASSURANCE
COMPANY AND METROPOLITAN LIFE
INSURANCE COMPANY 7359

THE MEDICAL COUNCIL OF CANADA 7453



Ottawa, Ontario,
Thursday, 22nd
March, 1962.

--- On commencing at 10 a.m.

THE CHAIRMAN: Yes, Mr. Hall?

MR. HALL: Mr. Chairman, the next
submission is by Mr. K.O. Bardwell and I would ask that
this be filed as Exhibit 197.

--- EXHIBIT NO. 197: Submission of Mr. K.O. Bardwell

SUBMISSION OF MR. K.O. BARDWELL

MR. HALL: Mr. Bardwell, I understand
that you are submitting this brief as an individual.
Would you kindly tell the Commission who you are and
your purpose in appearing here?

MR. BARDWELL: If I may, I would read
the first page of this brief into the record as an intro-
duction.

This is a private submission which will
argue that the Government of Canada cannot in good
conscience offer a first national health services plan
which offers less than that now available to its own
employees and this is submitted by myself, K.O. Bardwell;
I am a Canadian citizen living at 110 Hopewell Avenue,
Ottawa 1.

1. When I appeared before this Royal
Commission on the first day of your hearings I indicated
my intention to argue that an existing private plan, in
which the government figures as employer-contributor,
sets a minimum of protection below which you cannot



1 reasonably expect any new national health services plan
2 to go. I hope to justify this position today and to
3 argue that certain services not presently paid for by
4 any plan should be included. I shall also have some
5 things to say about the postures struck by some of those
6 groups who have appeared before you during your hearings
7 across Canada.

8 2. Before starting these serious
9 arguments I should again introduce myself. I am an
10 employee of the Government of Canada, working in a
11 technical position in a department which has no connection
12 with health policies. My situation is thus, I believe,
13 politically insensitive. I am an Anglican who takes
14 seriously the Second Great Commandment: "Thou shalt
15 love thy neighbour as thyself". It is thus my Christian
16 duty to argue that the health insurance plan available to
17 me should also, in the absence of something better, be
18 used to protect my fellow Canadians, most of whom have
19 no real security in this field. Because I know of
20 related health costs which are not covered by any present
21 private insurance scheme I must argue for these to be
22 included. As a Canadian with strong national pride I
23 flinch each time some foreign news medium carries a
24 deservedly disparaging article on suffering brought about
25 by medical costs to uninsured or underinsured residents
26 of our country. As the husband of a multiple sclerosis
27 sufferer I have spent months of evenings at a local
28 hospital and have met many people whose worst problem is
29 not their illness but the cost of it. I must remind you
30 of the urgent need for a solution to their problem, which



1 is greater than that of any of the financially interested
2 groups who will argue for equivocation, delay, compromise
3 and continued neglect of the unfortunate.

4 MR. HALL: I believe, arising out of
5 the matters contained in your brief you have put forward
6 a number of recommendations; will you state those?

7 MR. BARDWELL: 3. My recommendations
8 to you are, briefly, that:

9 A: This Royal Commission should make
10 positive recommendations toward the
11 early establishment of a National
12 Health Services Plan.

13 B: This plan should be comprehensive ...
14 at least as comprehensive in its earliest
15 stages as that plan now covering the
16 employees of the Government of Canada
17 itself. (Copy of plan attached. Ex. 1)

18 C: To avoid predictable suffering this
19 plan must be compulsory for all working
20 employables. The government should pay
21 an equitable premium into the plan for
22 those not gainfully employed, whether
23 by reason of health, age or the current
24 state of the economy.

25 D: This plan should be to a national
26 minimum standard, so that no region
27 should offer substantially less than that
28 commonly available to Canadians in other
29 regions. Reciprocal arrangements should
30 be made with other friendly countries to



1 have medical care available to Canadian
2 nationals when outside Canada.

3 E: Dental, drug, therapeutic, nursing,
4 ambulance and other services which are
5 necessary to physical and mental good
6 health should be included. Transporta-
7 tion to treatment centres outside the
8 area of residence should be covered
9 when physicians certify that treatment
10 is not locally available.

11 F: This plan should be on a cost-sharing
12 premium deduction basis, as the present
13 Public Services Medical Plan is, with
14 employer and employee paying approxi-
15 mately equal shares. To reduce admini-
16 strative costs these premiums should be
17 lumped with other shared deductions so
18 that, eventually, we will pay one social
19 services deduction.

20 G: In a contributory scheme means tests
21 are not justified. Among those whose
22 contribution will be made up by the state
23 are many whose needs for subsistence are
24 met by other public bodies, often subject
25 to means tests which impose a beggarly
26 existence upon the recipient. Physical
27 handicaps should not be penalized.

28 Pensions for the blind, the physically
29 handicapped of all types should come
30 under the coverage of this scheme with



1 the inability to engage in remunerative
2 employment being the only test of quali-
3 fication for benefit. We now have under
4 way contributory schemes for pensions
5 for the aged and the unemployed which
6 will eliminate means tests for those
7 benefits but unless you recommend a
8 change in the systems of pensions for
9 the handicapped this most disgraceful
10 bar to aid to those least able to care
11 for themselves will remain.

12 H: Present provincial hospital insurance
13 practice should be altered so that it
14 is impossible for anyone to be uninsured.
15 The present T.V. spot commercials by
16 the Ontario Hospital Services Commission
17 illustrate how it can happen here but
18 few are aware of the financial disasters
19 which result from these exceptions to
20 an otherwise good scheme. The remarks
21 in "C" above apply, on the need for a
22 compulsory scheme.

23 I: Too much hospital space and medical
24 expense is tied up in avoidable accident
25 cases. Some extra incentive should be
26 given to provincial and local authorities
27 to reduce obvious causes of automobile
28 accidents, the largest single contributor
29 to avoidable medical expenses. The
30 responsibility of the medical profession



1 in this regard is mentioned.

2 J: Services to assist in the re-employ-
3 ment of the handicapped and of displaced
4 workers with limited physical capabili-
5 ties should be developed. In Britain
6 an official scheme gives preference to
7 plants employing a minimum percentage of
8 handicapped workers in government
9 contracts. This permits the employer
10 who cares enough to try to find special
11 uses for the handicapped to compete,
12 without subsidy, by simply making it
13 easier for him to schedule continuous
14 production. The methods of the Depart-
15 ment of Veterans' Affairs, which made
16 many special placements during and after
17 the war, should be able to help many
18 handicapped persons who want to find work.

19 K: The fields presently covered, or
20 thought to be covered, by the many volun-
21 tary agencies should be reviewed. This
22 area is apparently one of confusion,
23 avoidable omission and duplication. The
24 real resistance to the appeals of
25 Community Chests, etc. is due to public
26 feeling that many of these activities
27 are legitimate fields for real joint
28 action by agencies which are now dedi-
29 cated to the problems of one disease or
30 one segment of a problem only.



1 L: Measures to encourage recruitment
2 and dispersal for those medical person-
3 nel in short supply should be advanced.
4 The training of nurses could be encou-
5 raged by removing some of the financial
6 burdens to be borne by the trainee ...
7 in fact by paying more than a token
8 salary from the beginning of training.
9 We have in Canada the situation where
10 wards are allegedly closed because of
11 shortage of nurses and no extra incen-
12 tives are offered to speed recruitment
13 of trainees.

14 M: Your recommendations should provide
15 for review of the effect of the plan at
16 an early date (suggested time: 5 years).
17 No plan should be started without provi-
18 ding a definite review date for modifica-
19 tions and extensions to be considered.

20 MR. HALL: I understand since the prepara-
21 tion of your brief you have discovered some information
22 dealing with recommendation L; would you like to state
23 that?

24 MR. BARDWELL: Yes. Some recently
25 published figures on this, just this last week as a
26 matter of fact give us a movement of nurses in and out
27 of Canada and this is in excess of 12,000 each way. I
28 feel that we are probably losing young, recently trained
29 nurses and in the statistics of incoming nurses we are
30 probably getting many older married women so the balance



1 is not coming out one to one.

2 COMMISSIONER GIRARD: Did you 12,000?

3 MR. BARDWELL: 12,000 per year, that
4 is the figure.

5 THE CHAIRMAN: What is your authority
6 for that?

7 COMMISSIONER GIRARD: I thought it was
8 1,200.

9 MR. BARDWELL: I rather doubt that -
10 no, we have here - may I quote a particular newspaper?

11 THE CHAIRMAN: Yes indeed.

12 MR. BARDWELL: From the Ottawa Citizen
13 and it is quoting the Labour Gazette for January and
14 it says that the number who entered Canada was 12,616,
15 this is nurses, and 12,834 left Canada.

16 COMMISSIONER GIRARD: During the year?

17 MR. BARDWELL: During the year, yes.

18 COMMISSIONER GIRARD: Well, I cannot
19 deny it because I have not got the figures but I think
20 we should look into those figures - it must be an error.

21 COMMISSIONER McCUTCHEON: I did not
22 think we had that many in Canada.

23 COMMISSIONER GIRARD: In Canada - the
24 official number of nurses in Canada is between 58,000
25 and 60,000 nurses and I am sure this is around 1,200.
26 The figure I have always quoted is around 1,200 so this
27 may be a misprint.

28 MR. BARDWELL: I doubt it because the
29 total quoted - I am sorry, this is a ten-year period.

30 COMMISSIONER GIRARD: Yes, that is



1 exactly it, for a ten-year period it comes down to 1,200.

2 THE CHAIRMAN: If you went into the
3 42,000 we would know right away.

4 MR. BARDWELL: In any event, if the
5 balance still runs out even I do think it is important
6 that we attempt to help Canadian-trained people in
7 Canada and I do not really think a person trained under
8 another system is quite an exact exchange at an initial
9 point.

10 THE CHAIRMAN: Does it say how many of
11 the 12,000 incoming were nurses who had left Canada in
12 the first place and simply made a circle? We are told
13 there is a regular circle, something like ---

14 MR. BARDWELL: I realize this but does
15 this recontribute anything to the standard of service?
16 Canada is becoming a tourist point in this sort of thing.

17 THE CHAIRMAN: What suggestion could
18 you make that would impede that movement? A young girl
19 who finishes her training, how can you tie her to one
20 place? She graduates in Toronto and is beckoned by the
21 sunny skies of Victoria; she hears how beautiful it is
22 in Los Angeles and then on to Florida and a little later
23 she is back in Toronto.

24 MR. BARDWELL: I think in the first
25 place if they did not have such a poor financial term
26 for the three years of their training they may not be
27 quite so quick to look elsewhere. I think some of them
28 leave Canada with rather bitter memories of the - well,
29 it is hardship all during their period of training.

30 THE CHAIRMAN: While you are speaking of



1 that, we have had no suggestion of any bitterness by
2 those appearing before us at the conclusion of training
3 and I think I probably have attended as many nurses'
4 graduations as any man around and I always thought they
5 were a happy group.

6 MR. BARDWELL: At any rate, they
7 certainly are in short supply. At every point I have
8 lived there has always been a nursing shortage and there
9 is a nursing shortage here now in Ottawa.

10 THE CHAIRMAN: Well, these are your
11 figures at any rate.

12 MR. HALL: In paragraph 9 on page 6,
13 you start out by saying there should be no impediment
14 to Canadians moving from place to place. Will you tell
15 us what you mean by that?

16 MR. BARDWELL: In our personal system
17 a person is tied to a group plan which his employer
18 carries; if anything happens to him, if he or any of
19 his dependants fall ill, then he is tied to that employer
20 for perhaps the rest of his life.

21 In my particular instance I could not
22 afford to leave the Federal Civil Service because I have
23 ten thousand dollars worth of prepaid medical coverage
24 and I have a wife who has multiple sclerosis. Therefore,
25 my mobility is very seriously impeded. I do not think I
26 could afford to change jobs unless I had the right of all
27 British subjects and went home to Britain which is not
28 my home. This is the only way I could solve my medical
29 expenses problem if I wanted to change jobs.

30 There is no employer in the country who



1 would accept my wife as a medical risk so there is a very
2 serious impediment of movement in our absolutely hap-
3 hazard system.

4 MR. HALL: Paragraph 12 on page 7, you
5 make reference to means tests; would you elaborate on
6 that from your point of view as an employee?

7 MR. BARDWELL: Well, I have mentioned
8 here the means test as it is applied to the physically
9 handicapped in this particular province. The figure
10 given me was \$1,600; if a woman has been working and
11 she is incapacitated and her husband brings their joint
12 income up over \$1,600 a year she is ineligible to be
13 sustained.

14 You cannot live in urban society for
15 that amount, it only applies to welfare cases. They
16 are shuffling off another category of welfare cases into
17 another act and that is what it means under present
18 conditions.

19 At the time the Act was drawn it might
20 have been very apt. Now, we know that in some towns in
21 this area, in Cornwall, for instance, one family in
22 every 11 is on relief and they are already facing means
23 tests and every time under a plan which would have a means
24 test, every time they had to give them medical services
25 they would be insulted again by the means test.

26 I consider the means test to be insult-
27 ing.

28 If I may go back to a book which is
29 heard a lot of at Christmastime, almost as much as a
30 bible, A Christmas Carol, by Charles Dickens; I would



1 like to read something which fits what has been said by
2 people who appear before this body:

3 "'Are there no prisons?,' asked Scrooge.

4 'Plenty of prisons,' said the gentleman,
5 laying down the pen again.

6 'And the union workhouses?,' demanded
7 Scrooge. 'Are they still in operation?'

8 'They are. Still,' returned the gentle-
9 man, 'I wish I could say they were not.'

10 'The treadmill and the Poor Law are in
11 full vigour, then?,' said Scrooge.

12 'Both very busy, sir.'

13 'Oh! I was afraid, from what you said
14 at first, that something had occurred
15 to stop them in their useful course,'
16 said Scrooge. 'I'm very glad to hear
17 it.'

18 'I wish to be left alone,' said Scrooge.

19 'Since you ask me what I wish, gentlemen,
20 that is my answer. I don't make merry
21 myself at Christmas, and I can't afford
22 to make idle people merry. I help to
23 support the establishments I have men-
24 tioned - they cost enough; and those who
25 are badly off must go there.'

26 'Many can't go there; and many would
27 rather die.'

28 'If they would rather die,' said Scrooge,
29 'they had better do it, and decrease the
30 surplus population. Besides - excuse



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1 me - I don't know that.'

2 'But you might know it,' observed the
3 gentleman.

4 'It's not my business,' Scrooge
5 returned. 'It's enough for a man to
6 understand his own business, and not to
7 interfere with other people's. Mine
8 occupies me constantly. Good-afternoon,
9 gentlemen!'"

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11 -

12 -

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14 -



1 Now this to me just about covers the
2 philosophy of some of the modern people who know what
3 is considered to be morality in the rest of the
4 Christian world and they still come before you and say
5 the concern of others is not their business. That
6 Canadians can arrange their own medical care systems
7 and that they would leave them at that.

8 COMMISSIONER BALTZAN: Mr. Chairman may I
9 just at this juncture get an explanation from Mr.
10 Bardwell? May I do so now, Mr. Chairman?

11 THE CHAIRMAN: Yes.

12 COMMISSIONER BALTZAN: You raise a point
13 in 12, on page 7. Please correct or explain to me --
14 actually here you are referring to the terms of the
15 means test not the method of the means test?

16 MR. BARDWELL: This is true but then one
17 must consider what means test does mean to us today.
18 If the means test were to be revamped ---

19 COMMISSIONER BALTZAN: Well we will come back
20 to that a little bit later but here in this paragraph
21 the actual reference is to the terms of the means test?

22 MR. BARDWELL: Yes.

23 COMMISSIONER BALTZAN: Certain restrictions,
24 etc. not the means test itself which we will discuss
25 a little bit later.

26 MR. BARDWELL: Yes, that is true. In a
27 later reference I say that on a contributory scheme no
28 reference to a means test is justified.

29 COMMISSIONER BALTZAN: We will discuss that.

30 THE CHAIRMAN: Now would you explain that?



1 A contributory system pre-supposes that all will
2 contribute?

3 MR. BARDWELL: Well the supposition is, as
4 I have put it forward here, that all who are employed
5 would contribute and for those who are unemployed by
6 reason of health, age or the current state of economy ---

7 THE CHAIRMAN: So that you have categories?

8 MR. BARDWELL: You have a contribution going
9 for them nevertheless.

10 THE CHAIRMAN: But they would not be making
11 it themselves?

12 MR. BARDWELL: Oh this is true, because they
13 are physically unable.

14 THE CHAIRMAN: Just accept, if you will, and
15 do not be too apprehensive of what I am coming to.

16 MR. BARDWELL: I am sorry sir.

17 THE CHAIRMAN: I am not trying to lead you
18 to a trap. I just want to deal with this question of
19 some method of identification of person. So you
20 start off with the proposition that all will contribute?

21 MR. BARDWELL: Yes, or will be contributed
22 for.

23 THE CHAIRMAN: All less A, B, C and D?

24 MR. BARDWELL: Yes.

25 THE CHAIRMAN: You say the ill, the unemployed,
26 and so forth and etc. Doesn't that necessarily take
27 you to some form of inquiry?

28 MR. BARDWELL: Well generally the inability
29 to engage in gainful employment I think should be the
30 only terms of reference.



1 THE CHAIRMAN: Well even if you accept that,
2 then that is an inquiry?

3 MR. BARDWELL: Yes, but this certainly is
4 not detailed dredging into your financial affairs
5 that must occur now under the present setup.

6 THE CHAIRMAN: From then it is merely a
7 question of the depth of the inquiry?

8 MR. BARDWELL: Well in order to give an
9 answer on anything sir you must set a condition. The
10 same condition: ability to engage in employment.

11 THE CHAIRMAN: Would you look upon that as
12 something degrading to the personality of the ---

13 MR. BARDWELL: No, it is a fact which
14 obviously has to be faced. If one cannot work then
15 one avails oneself of the insurance system which the
16 State has set up.

17 THE CHAIRMAN: May it not be that a person
18 may be as sensitive of his physical disability as he
19 is of his financial disability?

20 MR. BARDWELL: I rather doubt that sir. At
21 any rate so far as his sensitivity is concerned his
22 family would not necessarily suffer. As it is, if he
23 doesn't go through it his family will suffer.

24 I know a particular instance of this. A
25 woman who died, not of multiple sclerosis but of the
26 actual neglect which occasioned from her not having
27 proceeded through the channels that were available.
28 As I have just quoted here some would rather die.

29 Dickens is frequently used by the people
30 on the other side of the Iron Curtain to portray



1 incidents which they would have their people believe
2 are commonplace in our country. I have used this only
3 as an example of what I consider to be a retrograde
4 philosophy.

5 COMMISSIONER STRACHAN: Would it be
6 possible sir for a man to have a considerable bank
7 account and be unemployable?

8 MR. BARDWELL: Well basically I would contend
9 that this is reason of his thrift and is irrelevant
10 although I know there was a celebrated case in the
11 United States of a man who was on public assistance
12 who earlier, from what he had saved from the public
13 assistance, had invested it and made himself a small
14 fortune on the side and he was held to be guilty of
15 some finagling.

16 COMMISSIONER McCUTCHEON: Would you have
17 acquitted him?

18 MR. BARDWELL: I don't know. I would hate
19 to have to try his case. He had lived on the granted
20 amount and he had lived at a penurious level.

21 THE CHAIRMAN: All that is involved is the
22 suggestion that there is to be an acceptance of
23 some form of inquiry. Now an inquiry is a nice polite
24 word but when you use the words "means test" you
25 apply a nasty connotation to it but in fact is there
26 any difference?

27 MR. BARDWELL: Where the connotation is so
28 obvious, and if you were to ask for information and
29 your income is slightly in excess of their figure,
30 they would not even go through the inquiry. They just



1 write it off so there is no variability about it.
2 You have to go down to sub-level, dead broke,
3 in order to benefit from many of these things which
4 are provided by Statute now but are absolutely
5 excluded by the cost of living from people who were
6 originally intended to have them so the means test
7 that we have in many pieces of legislation invalidates
8 the legislation.

9 THE CHAIRMAN: Going to H on page 3 -- you
10 don't need to rise unless you prefer to.

11 MR. BARDWELL: I feel better sir.

12 THE CHAIRMAN: Some people are more assertive
13 on their feet. You are free to do whatever you like.
14 On page 3:

15 "Present provincial hospital
16 insurance practice should be altered
17 so that it is impossible for anyone
18 to be uninsured."

19 Now just what do you mean by that?

20 MR. BARDWELL: Well I would simply mention
21 the difference between Quebec Hospital Insurance
22 Scheme and the Ontario Hospital Insurance Scheme. I
23 think this illustrates it. A resident of Quebec
24 is insured. A resident of Ontario may be insured and
25 five per cent of them are not insured.

26 THE CHAIRMAN: Who are these five per cent
27 who are not?

28 MR. BARDWELL: These are people who work
29 for employers who have less than fifteen employees.
30 People who are self-employed and people who are not



1 obligated under the law to be covered.

2 Now there are a number of other people who
3 are not obligated who can avail themselves of the
4 coverage by paying privately, but nevertheless five
5 per cent of them do not avail themselves of that
6 coverage and when they end up in the hospital their
7 world comes to an end.

8 I know of one case in Ottawa of a woman who
9 booked herself out after having been in a few days
10 following a heart attack. She was so afraid of the
11 bill that would come. Certainly she was not released
12 by her doctor.

13 COMMISSIONER McCUTCHEON: Why didn't she
14 pay her premium?

15 MR. BARDWELL: That is a very good question.
16 At that stage can you be vindictive? The legislation had
not set up compulsion.

17 COMMISSIONER VAN WART: Under your federal
18 schemes not all civil servants avail themselves of it.

19 MR. BARDWELL: No, this is true.

20 THE CHAIRMAN: What is the answer to that?
21 To those who do not avail themselves of it?

22 MR. BARDWELL: Well the answer is the same
23 as it has been for other fringe benefits in the
24 Government, it just obviously in the future some time must
25 develop a policy of deducting it, as there are a
26 number of deductions you must pay. For instance,
27 everyone who works must pay income tax. You must
28 contribute to a number of other things.

29 THE CHAIRMAN: That is another story. The
30 matter of a health scheme such as the Dominion



1 Government has pays 50 per cent of the cost. You say
2 there are a number of civil service employees who do
3 not elect to participate.

4 MR. BARDWELL: They won't put up their own
5 half so as to benefit from the Government's half.
6 They know that in the event they become indigent they
7 can use the existing mechanism. There are free loaders
8 in every level.

9 THE CHAIRMAN: What is their percentage?

10 MR. BARDWELL: I am afraid I cannot tell you
11 that. There were a number of people who had other
12 schemes and some of them are carrying on this scheme
13 still.

14 THE CHAIRMAN: Some of them are carrying them
15 both?

16 MR. BARDWELL: Yes.

17 THE CHAIRMAN: That is what we heard. In
18 fact it was in Manitoba I think there were a number --
19 Manitoba or Saskatchewan carried on both.

20 COMMISSIONER VAN WART: You are in favour
21 of a system which would compel those people to pay a
22 premium and enter a scheme?

23 MR. BARDWELL: I would think so because as
24 I say when they are ill you have to give them coverage.
25 This is part of our Christian philosophy and they do get
26 the services and yet when they get those services, if
27 they do not pay for them then the cost of their
28 service goes on the cost of the services that are paid
29 for by other people.

30 I have often suspected that the cost of



1 medical service in Canada is inflated by as much as
2 20 per cent to the person who does pay by the fact
3 that the other people do not pay. Our hospitals
4 had a lot of trouble collecting some of their bills
5 back in the days when they had to collect them. I
6 am sure that doctors had the same trouble. I am
7 sure also that doctors do not really forgive those
8 debts. They add them on the bills of people who do
9 pay and the doctor does not suffer by the fact that
10 some people do not pay.

11 I can remember in the past having neighbours
12 who had available to them the same schemes as I had,
13 and some of them in fact had better incomes. They
14 went to the same clinic as my wife did. When their
15 children were born they had the best gynaecologist
16 yet they had an adjustment with the clinic which means
17 they did not pay their bills and dead beating is
18 becoming an established thing under this system. This
19 is the prime advantage of compulsion that you will get:
20 some Canadians who never carried any obligation will
21 now carry their first responsibility.

22 THE CHAIRMAN: You say this Federal scheme
23 is a good thing?

24 MR. BARDWELL: Yes sir.

25 THE CHAIRMAN: Then you advocate some form
26 of national scheme equivalent, in any event, but
27 different and perhaps better?

28 MR. BARDWELL: Yes. That is what I
29 anticipate.

30 THE CHAIRMAN: In this National scheme that



1 you would like to see what becomes of the Federal
2 scheme?

3 MR. BARDWELL: Well actually the Federal
4 scheme is probably, as I see it, operated at really
5 just a service charge by the insurance companies.

6 THE CHAIRMAN: Would you see that disappear?

7 MR. BARDWELL: What I mean --

8 THE CHAIRMAN: Merged or would you just have
9 the Government cover everybody under this through a
10 great deal of private insurers, such as they do now.
11 I am just trying to get what you mean?

12 MR. BARDWELL: I see no objection to an
13 insurance company managed scheme at a management fee
14 where it is managed to a certain stipulated standard.
15 That is, where they offer a standard arrangement.

16 THE CHAIRMAN: You mean no lower than the
17 present and perhaps better?

18 MR. BARDWELL: That is right, and it could
19 be operated by any number of firms privately only
20 that their profit was as a public utility.
21 A limited profit. They are doing the paper work which
22 would otherwise have to be done by a new department
23 of Government if you were to set it up.

24 THE CHAIRMAN: The experience of the Government
25 scheme appears to be that they are able to extend the
26 benefits?

27 MR. BARDWELL: That is right. They have in
28 fact been able to extend their total coverage, that
29 is from \$5,000.00 to \$10,000.00 under the major medical
30 benefits over the period that it has been in force.



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1 THE CHAIRMAN: Is it \$50.00 deductible or
2 is it \$25.00 deductible? \$25.00 per person?

3 MR. BARDWELL: \$25.00 for an individual or
4 \$50.00 for a family.

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1 THE CHAIRMAN: Do you find that a detri-
2 ment?

3 MR. BARDWELL: It probably has a good
4 deterrent effect. I have heard a lot of complaints
5 about it.

6 THE CHAIRMAN: Is it regarded by and
7 large from what you have heard as being satisfactory or
8 unsatisfactory?

9 MR. BARDWELL: Most people object to it.
10 It was originally put in as a deterrent. I can see why
11 it was included there; and when you are talking about
12 massive expenses you don't notice the first fifty.

13 THE CHAIRMAN: Oh, no; if you have a
14 couple of thousand and you get 1,600 to that, \$50 isn't
15 too important at that stage.

16 MR. BARDWELL: I notice someone in a
17 recent submission had suggested that the medical expenses
18 as allowed towards income tax should be increased; I
19 believe that was their general reference, rather than
20 offering a general scheme to people who were not indigents.

21 They suggested the present method of
22 allowing medical expenses should be utilized. I have a
23 serious objection to this. I don't particularly enjoy
24 having a rebate from my income tax coming every year,
25 and there must be a lot of other people are paying
26 medical expenses and getting most of it back in any
27 event.

28 I don't see why there should be a delay
29 in recouping it. I am paying most of my income tax every
30 year.



1 COMMISSIONER McCUTCHEON: Let's say in
2 a medical scheme, you would be happy to see the same
3 terms as the Government scheme?

4 MR. BARDWELL: Yes.

5 COMMISSIONER McCUTCHEON: You say
6 extended to all employed persons?

7 MR. BARDWELL: Yes, extended to all
8 employed persons, with unemployables.

9 COMMISSIONER McCUTCHEON: You contemplate
10 some law which would require employers to make the same
11 contribution presumably the Federal Government makes?

12 MR. BARDWELL: Yes.

13 COMMISSIONER McCUTCHEON: And the
14 employees would make the same contribution as the civil
15 servants in the scheme?

16 MR. BARDWELL: Yes.

17 COMMISSIONER McCUTCHEON: What about the
18 self-employed?

19 MR. BARDWELL: Well, this again is a
20 serious problem, it always has been everywhere, when they
21 are setting up any kind of an insurance scheme. But I
22 still think these people should be covered.

23 COMMISSIONER McCUTCHEON: How are they
24 going to be covered - the lawyers, chartered accountants,
25 farmers?

26 MR. BARDWELL: Well, most of the groups
27 you have mentioned can afford to pay the double premium.
28 I say I won't extend this necessarily to the farmers.

29 COMMISSIONER McCUTCHEON: I just wondered
30 how you cover that group, the farmers, fishermen, the man



1 who goes out and cuts wood in the wintertime.

2 MR. BARDWELL: If I may put a question:
3 who pays their bills now?

4 THE CHAIRMAN: Mr. Bardwell, our proposi-
5 tion is not to have a philosophical discussion on it but
6 the mechanics. It is easy to say to the employer we
7 will have to have a return and make a deduction, his
8 share and what he is taking away from the employee and
9 sending it in. You are going to insure all the workers,
10 those who are working and the others. How are you going
11 to send in their premiums, the mechanics of that?

12 MR. BARDWELL: There is no difficulty
13 about collecting income tax from them and a number of
14 other things we collect from them. It doesn't have to
15 be on a monthly basis as long as you get a settlement
16 from them.

17 THE CHAIRMAN: Let's follow that. It
18 is your thinking that a person could be prosecuted
19 because he is failing to pay his income tax?

20 MR. BARDWELL: Yes, because he is
21 running a risk he shouldn't be permitted to run.

22 THE CHAIRMAN: What would you do with
23 the fellow who just refused to pay apart from prosecuting
24 him? What about his coverage?

25 MR. BARDWELL: I don't think that you
26 really can permit this situation to develop on a large
27 scale in any event, because you will have the situation
28 you have now, people will be sick and having been sick
29 they want all the benefits of the system.

30 THE CHAIRMAN: Would you give them



1 coverage if they took sick?

2 MR. BARDWELL: I am afraid you would
3 have to.

4 THE CHAIRMAN: What do you mean, you
5 would have to? This farmer and others perhaps could
6 well afford to pay. In the meantime, are you going to
7 give him coverage?

8 MR. BARDWELL: Yes, but you are going
9 to have to have a penalty after the act. You can't let
10 him die by the wayside.

11 COMMISSIONER McCUTCHEON: He is not
12 going to die by the wayside; he has plenty of money.
13 There are wealthy farmers.

14 MR. BARDWELL: Yes, I am aware of this.
15 You are talking about the non-conformist, who will not
16 conform to the system?

17 COMMISSIONER McCUTCHEON: Yes.

18 MR. BARDWELL: Well, as we have a
19 penalty in every other law, we will have to have a
20 penalty for that.

21 THE CHAIRMAN: Are you going to have a
22 different one to the one who is a poor farmer?

23 MR. BARDWELL: I am afraid so.

24 THE CHAIRMAN: How are you going to
25 determine the classification between a poor farmer and
26 a wealthy one?

27 MR. BARDWELL: You are dealing with ---

28 THE CHAIRMAN: 20,000,000 people.

29 MR. BARDWELL: 20,000,000 dissentants?

30 THE CHAIRMAN: No, roughly 19,000,000



1 population. You say 5% of Ontario is not covered now.
2 5% of 6,000,000 is 300,000.

3 MR. BARDWELL: There is no penalty now
4 under the present legislation, otherwise we wouldn't
5 have 5%.

6 THE CHAIRMAN: This is going to assist
7 you in your thinking. There is a penalty in Saskatchewan.

8 MR. BARDWELL: Yes.

9 THE CHAIRMAN: And do you know there is
10 a percentage there who can't pay?

11 MR. BARDWELL: I have no doubt of this.
12 I know of a man who hanged himself because they insisted
13 he should pay his income tax. This was a man who was
14 very determined in his thinking.

15 THE CHAIRMAN: I happen to know more of
16 that than anyone else, I suppose?

17 MR. BARDWELL: Yes, it was in your
18 jurisdiction, I suppose?

19 THE CHAIRMAN: My client. But I think
20 the suggestion that he hanged himself because of income
21 tax was not right.

22 MR. BARDWELL: I had it from the news-
23 papers.

24 COMMISSIONER VAN WART: A man has rights
25 to refuse a blood transfusion.

26 MR. BARDWELL: Yes.

27 COMMISSIONER VAN WART: Use other types
28 of treatment.

29 MR. BARDWELL: Yes.

30 COMMISSIONER VAN WART: Hasn't he the



1 right to refuse insurance to protect his health?

2 MR. BARDWELL: Well, I presume he has
3 that providing he is also willing to sign away his
4 right to care when he is sick. I think if you were to
5 do this mercy killing would become legitimate, if you
6 were to carry the right that far.

7 THE CHAIRMAN: Any further questions?

8 COMMISSIONER BALTZAN: Mr. Bardwell,
9 on page 3, item I, you make a statement to the effect,
10 and I quote:

11 "Too much hospital space and medical
12 expense is tied up in avoidable accident
13 cases".

14 My question is: have you statistical
15 knowledge about how much hospital space in support of
16 the statement that too much hospital space is tied up
17 in avoidable accident cases.

18 MR. BARDWELL: Well, I haven't a figure
19 here with me, but I do recall reading within the last
20 two months that the automobile accident rate in Canada is
21 than that in the United States. American authorities
22 contend that theirs certainly could be reduced. Now,
23 I was referring particularly to the responsibility of
24 the medical profession in reducing the number of acci-
25 dents.

26 Now, the medical profession have been
27 all ethics at all times, but I think that they of all
28 the groups in society should be the ones to do what is
29 required in reducing accidents, and I think the doctor
30 concerned, without mentioning any of these, probably



1 feels some responsibility because his client had been
2 under treatment for a disease that later caused him to
3 die at the wheel, or in two instances involved people in
4 public life, they claimed when in court that they had
5 taken drugs at the same time when drinking and they were
6 incapacitated. So it seems to me that it is not right
7 that a law should stay on the books and there be a
8 liability pertaining only to liquor.

9 COMMISSIONER BALTZAN: We are not here
10 to consider the defence of the medical profession or
11 otherwise. But in this connection the responsibility of
12 the medical profession in this regard is mentioned, and
13 you have already mentioned that they have a greater
14 responsibility.

15 MR. BARDWELL: Yes.

2 16 COMMISSIONER BALTZAN: And you have
17 just said a minute or two ago about someone driving
18 while drunk. Is it anybody else's fault except the
19 drunkard who drives the car?

20 MR. BARDWELL: No. I am simply saying
21 that the law at the moment applies to anyone driving
22 while drunk or taking drugs where they have acquired a
23 habit. Now, people have been able to use this as a
24 defence, taking drugs, and doctors have agreed with
25 this. I think they should be cautioned, the same as an
26 unsafe driver.

27 COMMISSIONER BALTZAN: I agree with you.
28 For instance, the patient who takes insulin for diabetes
29 under doctor's orders, that person can have an overdose
30 of insulin.



1 MR. BARDWELL: Yes.

2 COMMISSIONER BALTZAN: Is it the person
3 who prescribes it who is responsible or the person who
4 is taking it who is responsible?

5 MR. BARDWELL: In that instance it is
6 the patient.

7 COMMISSIONER BALTZAN: In other words,
8 to put this in its proper place, it isn't a group or
9 even a law that regulates this, but so much of it comes
10 under the aegis of the individual's conscience and rules
11 of behaviour.

12 MR. BARDWELL: Well, we have a number
13 of categories of people, including people who are subject
14 to fits who must state this on the application. I think
15 the general health of the person driving should be
16 considered.

17 COMMISSIONER BALTZAN: I am sure you
18 are so well informed that you know that people have a
19 fitness examination before driving.

20 MR. BARDWELL: In this province, sir?

21 COMMISSIONER BALTZAN: I am not acquainted
22 with Ontario.

23 MR. BARDWELL: Not in Ontario.

24 THE CHAIRMAN: No.

25 COMMISSIONER BALTZAN: Not in Ontario?

26 THE CHAIRMAN: Not anywhere.

27 COMMISSIONER BALTZAN: Certain indivi-
28 duals of certain ages, before they get their licence,
29 get a medical examination before they get their licence.

30 MR. BARDWELL: This wasn't intended as



1 a point, but it should be a point in any scheme that
2 they should reduce any extra load that is put on the
3 hospitals.

4 THE CHAIRMAN: The Safety Council is
5 fairly active in that accident prevention work.

6 MR. BARDWELL: Yes, but there is no
7 restriction on people other than a few stated physical
8 conditions to prevent them from driving. In a period of
9 two months, I believe, here we had two people die at the
10 wheel in Bank Street.

11 THE CHAIRMAN: If we were able to state
12 the time and day of a man's death we would have no
13 accidents.

14 MR. BARDWELL: Yes, it is true, but I
15 would be afraid to face the man on the other side of the
16 wheel who shouldn't drive.

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1 COMMISSIONER FIRESTONE: Mr. Bardwell, I
2 have no questions. Your brief was fairly complete,
3 but I want to say this to you, that we are grateful to
4 you for having presented to us the views of the users
5 of health services. We have heard a great deal from
6 the suppliers of health services, and you have been very
7 helpful to us in presenting the other side of the
8 problem.

9 I personally have been very much impressed
10 by your sincerity in pleading the case for a
11 national, comprehensive health care program for Canada,
12 and I am sure the Commission will bear in mind the
13 Second Great Commandment which you have brought to our
14 attention when the Commission considers the submission
15 of their proposals to the Canadian Government.

16 Thank you very much.

17 COMMISSIONER STRACHAN: Recommendation E:

18 "Dental, drugs, therapeutic,
19 nursing, ambulance and other services
20 which are necessary to physical and
21 mental good health should be
22 included."

23 Have you given serious consideration to the costs
24 which would be involved?

25 MR. BARDWELL: On the cost of dental care in
26 particular, some figures quoted in the Citizen of
27 September 12th of last year, apparently federal
28 statistics, list the income tax receipts from various
29 professional groups, and apparently we paid a quarter
30 as much last year to dentists as we paid to doctors as



1 a group, and I suppose that if you were to assume that
2 people get the same care that they got last year, you
3 would have to add another twenty per cent to the cost
4 of your premiums, to include dental service.

5 Most of the other items I mentioned are
6 covered under this scheme, but not under most general
7 schemes.

8 COMMISSIONER STRACHAN: We were reliably
9 informed the other day that under the British Health
10 Scheme the dental costs are equal or greater --

11 MR. BARDWELL: The British must have worse
12 teeth than we have then, if you will accept that we
13 are getting satisfactory service, because we are
14 spending only 20 per cent of the total, not 50 per cent.

15 COMMISSIONER STRACHAN: Have you given any
16 consideration to the personnel that you would require
17 for such conditions?

18 MR. BARDWELL: You would anticipate then
19 that if people were covered for these they would be
20 getting services which they are not now getting. You
21 are admitting something that many of the people before
22 you haven't admitted, that is you consider that the
23 people are not getting the service that they would get
24 if it were available to them. I was not prepared to
25 argue that. I was prepared to argue simply on the
26 basis that presumably most people would continue at
27 about the same standard that they have, except of
28 course in dental services. It is quite apparent
29 to anyone who has had anything to do with straightening
30 children's teeth it is going to cost a lot more if they



1 start straightening the teeth of every child who needs
2 orthodonty.

3 COMMISSIONER STRACHAN: Can you foresee the
4 time when they would receive it?

5 MR. BARDWELL: Yes.

6 COMMISSIONER STRACHAN: Well, it takes
7 personnel and many years of training. We haven't got
8 the bodies in Canada to do it.

9 MR. BARDWELL: In that case, we must attempt
10 to enlarge our training system to provide these people.
11 This would amount to an admission of approaching
12 national emergency in that field.

13 COMMISSIONER STRACHAN: Then you admit that
14 there is something more basic than just stating it?

15 MR. BARDWELL: I was taking costs as they
16 are, which are the only solid figures I have available,
17 and I know that offering a scheme which covers the
18 entire population has not apparently changed the
19 proportion which is spent on medical care in total
20 in various countries. The figures for all of the
21 western countries, I believe, run something between
22 three and five per cent of their gross national
23 income. The disparity is not that great, depending
24 on the scheme. As we have it, cover yourself as you
25 will, or a national increase. I hadn't realized the
26 dental shortage was quite that great.

27 COMMISSIONER STRACHAN: The point I am
28 trying to make is that I don't think you have looked
29 into all the aspects of this, to make such a statement.

30 MR. BARDWELL: No, my last big dental expense



1 was when my daughter reached the stage of needing
2 orthodonty, and I have stayed away from the dentist
3 since then as much as possible.

4 COMMISSIONER STRACHAN: It is your privilege.

5 THE CHAIRMAN: Thank you very much Mr.
6 Bardwell. We wouldn't want you to think from the
7 questioning that there was anything but pleasure in
8 seeing you here this morning, and we are grateful to
9 you for having come.

10 MR. BARDWELL: If I might ask a question?

11 THE CHAIRMAN: Yes.

12 MR. BARDWELL: That is, at the commencement
13 of these hearings I had understood that the Ottawa
14 hearing would be the concluding one.

15 THE CHAIRMAN: There will be another hearing
16 in Ottawa, Mr. Bardwell, that is what was said at the
17 time, a sort of a catch-all, rebuttal hearing, the
18 date of which has not been announced.

19 MR. BARDWELL: And at that time, without
20 presenting a further brief, may one present objections
21 and comments on others?

22 THE CHAIRMAN: There will be an opportunity
23 then for rebuttal statements.

24 MR. HALL: The next submission is by the
25 Canadian Physiotherapy Association. This brief will
26 be Exhibit No. 198.

27 ---EXHIBIT NO. 198: Submission of The Canadian
28 Physiotherapy Association.

29 SUBMISSION OF THE CANADIAN PHYSIOTHERAPY
30 ASSOCIATION



1 APPEARANCES:

2 Mme. F. Goulet

3 Mrs. Curtis Millar

4 Miss S. Morgan

5 MR. HALL: Representing the Association are
6 Miss Sally Morgan, its Director and Mrs. Curtis Millar.
7 The summary of the brief and recommendations will be
8 presented by Miss Morgan.

9 MISS MORGAN: The Canadian Physiotherapy
10 Association respectfully submits the following brief
11 to the Royal Commission on Health Services in the hope
12 that it will assist that body in its investigations
13 into the problem of health care for the people of
14 Canada. The recommendations and conclusions reached
15 in this brief are broadly applicable to the whole
16 country; specific details are being submitted through
17 provincial briefs.

18 This brief will discuss the following five
19 points:

- 20 1. The formation and function of the Canadian
21 Physiotherapy Association.
- 22 2. The role of physiotherapy in the treatment
23 of the patient.
- 24 3. The present standards of training and
25 practice of physiotherapy.
- 26 4. The present and future supply and shortage
27 of personnel and facilities.
- 28 5. Suggestions for meeting these needs.

29 The Canadian Physiotherapy Association is the
30 official body which represents physiotherapists across



1 the Dominion. Its purpose is to maintain high
2 standards of training and practice, and to keep its
3 members informed of professional and scientific devel-
4 opments. The physiotherapist works directly under the
5 physician to achieve the functional restoration of the
6 patient by the intelligent and skillful application of
7 exercise, electrotherapy and other physical means.
8 To provide the training in the necessary techniques and
9 basic medical sciences, there are now six approved
10 schools in Canada, each in a University Medical Faculty.
11 Three of these schools graduate combined physical
12 and occupational therapists; the remaining schools
13 offer separate courses in each therapy. Two-thirds
14 of the members of the Canadian Physiotherapy Association
15 are drawn from these Canadian schools and one-third
16 from non-Canadian schools. The 1060 Association
17 members -- plus approximately 250 non-Association
18 physiotherapists -- are employed in departments of
19 general, specialized, and rehabilitation hospitals,
20 in outpatient centres, private patient clinics, and
21 in the home. There is a present shortage of 532
22 therapists in those hospitals and centres with
23 established departments. These hospitals represent
24 less than one-half of the hospitals in Canada of over
25 50 beds. The serious shortage of therapists must be
26 overcome so that present treatment facilities can be
27 expanded and future demands for physiotherapy met.
28 Suggestions for increasing available personnel and
29 treatment facilities are as follows:

- 30 1. Training facilities for physiotherapists



1 must be enlarged by:

- 2 a) urging other universities to open
3 schools of physiotherapy.
4 b) enlarging the present schools where
5 possible.
6 c) training more teachers of physiotherapy.

7 2. The number of student candidates must be
8 increased by:

- 9 a) offering more financial assistance,
10 and encouraging each province to offer
11 dominion-provincial bursaries to students
12 working towards degrees or diplomas.
13 b) stimulating interest in physiotherapy
14 among high school students, both male and
15 female.

16 3. The number of physiotherapists remaining
17 in the profession must be increased by:

- 18 a) offering more postgraduate bursaries
19 for teacher's training, specialized
20 courses and research.
21 b) recognizing a salary scale which
22 takes into account years of training,
23 extra education, experience, and
24 degree of responsibility.
25 c) improving the organization of
26 departments by more widespread use of
27 clerical and housekeeping assistance
28 to relieve the physiotherapist of non-
29 professional duties.

30 4. Facilities for physiotherapy should be



1 extended to all institutions and
2 services providing care in acute and
3 chronic phases of illness by:
4 a) increasing medical and public
5 awareness of the value of physiotherapy.
6 b) extending the present health services.
7 c) expanding rehabilitation and
8 convalescent programs.

9 This brief has pointed out the twofold
10 shortage of physiotherapy personnel and facilities in
11 Canada. While some of the problems relating to the
12 shortage are the responsibility of the Association and
13 the universities, it is evident that more government
14 financial assistance for training graduate and under-
15 graduate physiotherapists is essential, and that every
16 attempt should be made to increase treatment facilities.

17 Sir, could I introduce Mme. Goulet, our
18 President?

19 THE CHAIRMAN: Does Mrs. Millar or Mme. Goulet
20 wish to add anything to your submission?

21 MRS. MILLAR: No, this is our complete
22 submission.

23 COMMISSIONER GIRARD: I would like to ask
24 either Miss Morgan or anyone of the others this question.
25 On page 9 you speak about the short working life of
26 the therapist because of the preponderance of women in
27 the profession, and the preponderance of women means
28 marriage and loss to the profession. Is this what you
29 are referring to?

30 MISS MORGAN: Yes.



1 COMMISSIONER GIRARD: Do you feel that when
2 a physiotherapist is married that she is absolutely
3 lost to the profession, or do you reclaim her services,
4 when she is married does she come back and either work
5 part-time and do some work in physiotherapy, as we
6 reclaim the married nurses now, or is she absolutely
7 lost?

8 MISS MORGAN: No, she is not absolutely lost.
9 Many graduate therapists do come back, who have married,
10 and the children have gone to school, so they are not
11 perhaps involved during the day, or they arrange to
12 have a sitter look after the children while they come
13 and do part-time work, but the big disadvantage to
14 this is that if they make over a thousand dollars a
15 year, by the time they have paid the baby sitter,
16 and the income tax comes off the husband's salary as
17 well, it is not financially beneficial for them to
18 come back in the field.

19 COMMISSIONER GIRARD: This problem has been
20 brought out in other fields, nurses also, because
21 this income tax problem is a problem. Have you any
22 recommendations?

23 MRS. MILLAR: It is difficult to make any
24 recommendations, except that all these organizations
25 who are concerned in this particular thing might be
26 able to make some representations to the Income Tax
27 Department for relief in these instances. I don't
28 know the mechanics that would be involved, but I should
29 think that could be explored.
30



1 COMMISSIONER GIRARD: Then your recommendation
2 would be that the professions who are targets for
3 this get together, that is nurses and others?

4 MRS. MILLAR: I would think so, yes.

5 COMMISSIONER GIRARD: And try to do something.
6 It does hamper the work of the married professional?

7 MRS. MILLAR: Undoubtedly. I think there
8 are a great many people who would like to take
9 advantage of it if they could.

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1 COMMISSIONER GIRARD: That is right.

2 Then, on page 11:

3 "Every general hospital of over 50
4 beds should be encouraged to build a
5 physiotherapy department".

6 First of all, if every hospital of 50
7 beds tried to organize a physiotherapy department would
8 you have the personnel?

9 MISS MORGAN: No.

10 COMMISSIONER GIRARD: Are you really
11 convinced that a 50-bed hospital would use the full time
12 of one physiotherapist?

13 MISS MORGAN: What has been done out
14 west, I think there has been some system of rotation
15 if the hospitals are fairly close; sometimes a physio-
16 therapist will go mornings to one hospital and to another
17 in the afternoon..

18 COMMISSIONER GIRARD: This would be two
19 hospitals sharing a physiotherapist and not really what
20 you are saying when you say that a 50-bed hospital should
21 have a full-time physiotherapist.

22 MME. GOULET: Depending on the hospital,
23 the 50-bed hospital could use a physiotherapist.

24 COMMISSIONER GIRARD: Thank you very
25 much.

26 COMMISSIONER BALTZAN: Ladies, I
27 appreciate very much the importance of your submission
28 but I have no specific questions to ask.

29 COMMISSIONER VAN WART: On page 2, 1A,
30 urging other universities to open schools of physiotherapy,



1 do you anticipate any difficulty to obtain staff for new
2 schools or present schools are enlarged?

3 MISS MORGAN: I think staff could be
4 provided. At the moment there are five teachers in
5 training across Canada to universities or maybe six, I
6 think, at the moment, if they were opened within a
7 period of ten years you could fairly well supply the
8 universities with staff. You start off with perhaps
9 16 students as they have in Manitoba or British Columbia
10 and it would take perhaps two staff to cope and next
11 year one could be added. You could start on a small
12 basis and gradually grow.

13 COMMISSIONER VAN WART: Over a period
14 of ten years?

15 MISS MORGAN: Yes, that is being rather
16 specific but let us say up until 1970 I think we could
17 provide the staff, yes.

18 COMMISSIONER VAN WART: Where are these
19 teachers trained?

20 MISS MORGAN: They are, at the moment,
21 trained at the University of Manitoba, McGill University
22 and the University of Toronto, not in the other three
23 universities. They are new at present and they are just
24 getting their own students under way and they feel they
25 cannot handle post-graduate students at the moment.

26 COMMISSIONER VAN WART: There are no
27 training schools in the west?

28 MISS MORGAN: No, not at the moment.

29 MRS. MILLER: Not for teachers.

30 COMMISSIONER VAN WART: That is what I



1 mean. Thank you.

2 THE CHAIRMAN: Mrs. Miller, your brief
3 is necessarily supplementary to the provincial briefs
4 and we have had considerable discussion in the submis-
5 sions of the various provinces and, therefore, it is
6 perhaps not necessary at this stage for us to go into the
7 matter in as much detail as we might otherwise have to
8 do.

9 The information you have given us in
10 this brief and your information this morning is going to
11 be of value and will be taken into consideration. I
12 want to express the thanks of the Commission to you
13 ladies for being here this morning.

14 We will have a short recess now.

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16 --- Short Recess
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1 MR. HALL: The next submission is by
2 the Canadian Tuberculosis Association which will be
3 filed as Exhibit 199.

4
5 --- EXHIBIT NO. 199: Submission of the Canadian Tuber-
6 culosis Association.

7
8 MR. HALL: Representing the Association
9 are the President, Dr. C.A. Wicks and Dr. C.W.L. Jeanes,
10 the Executive Assistant.

11 SUBMISSION OF THE CANADIAN TUBERCULOSIS

12 ASSOCIATION

13 Appearances: Dr. C.A. Wicks
14 Dr. C.W.L. Jeanes

15 MR. HALL: Dr. Wicks will present the
16 conclusions and recommendations of the Association.

17 DR. WICKS: Mr. Chairman and members of
18 the Commission: the Canadian Tuberculosis Association is
19 very pleased to have this opportunity to be represented
20 and appear before the Royal Commission on Health Services.

21 It is my honour to represent our Associa-
22 tion as its current President and I am pleased to have
23 with me our Assistant Executive Secretary, Dr. C.W.L.
24 Jeanes. Dr. Jeanes will help to answer any questions
25 you wish to ask.

26 It has been suggested I read to you the
27 summary and conclusions or recommendations of the official
28 report from our Association.

29 CONCLUSIONS AND RECOMMENDATIONS:

30 1. History and Development -

The Canadian Tuberculosis Association



1 has provided an organization whereby physicians and lay-
2 men could unite to provide services for the prevention
3 and treatment of tuberculosis in Canada.

4 2. Programme -

5 The programme has been to encourage
6 the development of tuberculosis services, both preventive
7 and curative, in all provinces. Although maintenance
8 of tuberculosis hospitals is now the responsibility of
9 provincial governments, the direction of many of these
10 hospitals is still in the hands of voluntary boards.
11 The Canadian Tuberculosis Association is now particularly
12 interested in early diagnosis, health education and rehabi-
13 litation. It has encouraged and developed a research
14 programme to study the best methods of dealing with this
15 disease.

16 3. Tuberculosis in Canada -

17 Although great progress has been made in
18 controlling tuberculosis, particularly in reducing
19 deaths, morbidity remains high, much hospitalization is
20 required and costs of tuberculosis have not been greatly
21 reduced.

22 4. Special Problems -

23 a/ Resistance is developing to present
24 drugs. It is essential that treatment
25 be continued for an adequate period of
26 time to prevent this happening.

27 b/ Reactivations and readmissions
28 continue on a high level.

29 5. Importance of Maintaining Adequate
30 Service



a/ Fulltime services will be required for overall direction of tuberculosis programmes. This will include supervision of case registers and certain institutions and clinics.

b/ Staff recruitment - There is difficulty in obtaining young physicians for staff appointments. Integration with other medical services, where possible, is suggested as a solution.

c/ Maintenance of chest clinics -

These become more and more important for diagnosis, treatment and follow up as emphasis changes from institutional care to domiciliary care.

6. Tuberculosis and Hospital Insurance
Plans -

The Canadian Tuberculosis Association believes that hospitalization of tuberculosis should be included in hospital insurance plans in the provinces, with consideration of integration of services where possible.

7. Federal Grants for Tuberculosis -

These have been very helpful in bringing tuberculosis services up to more adequate standards. These should be continued with special emphasis on maintenance and extension of the chest clinic services. Some modification as to regulations may be advisable.

8. Research -

The importance of the research programme



1 in Canada is outlined with sources of funds available.

2 9. Voluntary Effort -

3 The need for voluntary effort is empha-
4 sized. All phases of the programme are dependent on an
5 informed public.

6 MR. HALL: Would you care to say any-
7 thing by way of supplementing the conclusions and recom-
8 mendations of the contents of the brief?

9 DR. WICKS: Mr. Chairman, I would like
10 to call your attention to page 9 of the official report
11 and at the bottom of that page a list of names of the
12 members of the management committee for the Canadian
13 Tuberculosis Association.

14 In effect, these gentlemen are the
15 co-signers of this report. If I might I would like to
16 supplement and amplify to some extent the official report.

17 I would like, if I could, to give you,
18 to outline to you, some of the unsolved problems in
19 tuberculosis facing us in Canada today.

20 Before I do that perhaps I should
21 briefly, and I hope I will not over-simplify the problem,
22 tell you something about the disease of tuberculosis and
23 try to do this as briefly as possible.

24 First of all, all unborn children are
25 born without the cause of tuberculosis, the tubercle
26 bacilli. You are familiar with the fact it is a communi-
27 cable disease caused by a germ called tubercle bacilli
28 and newborn children do not have that germ in their bodies
29 and they, therefore, would not react to tuberculosis.

30 However, as we grow older, it is more



1 likely to become infected with these germs. If I may
2 use an example; the longer we live in this world the
3 more likely we are to get a cinder in our eyes. However,
4 this depends to some extent on the circumstances in
5 which we live; if you are living in a railroad yard,
6 and I am speaking of the days when trains burned coal,
7 we would perhaps get the cinder in our eye at an earlier
8 age.

9 If we are living in an area of dense
10 population and if we have a member of our family with
11 tuberculosis we are more likely to be infected at an
12 earlier age. When we become infected with it this tubercle
13 bacilli is small, our resistance is strong and nothing
14 much happens. The tubercle bacilli digs itself in, we
15 build a fence around it and it is a truce between the
16 tubercle bacilli and our bodies.

17 Mind you, it is just a truce because
18 they may escape at any time and cause tuberculosis.
19 That is why people who have positive tuberculin reactions,
20 that is, those who have tubercle bacilli in their bodies,
21 should have regular chest x-rays to determine what the
22 tubercle bacilli are doing on us and what we are doing
23 to them.

24 Now, only then if the amount of tubercle
25 bacilli is large or if our immunity is low does tubercu-
26 losis develop. In that case, unfortunately, tuberculosis
27 of the lung does not, in the early stage, cause any
28 symptoms; perhaps it would be better if people with early
29 tuberculosis broke out in a rash and this rash would
30 then call the attention of the individual to the fact



1 that something was wrong and he or she would seek medical
2 advice and tuberculosis would be found in an early stage.
3 That is why we have to x-ray the chest of people if we
4 want to find tuberculosis in the early stages.

5 Let us assume then that tuberculosis
6 has developed as revealed in the chest x-ray film and
7 we are recommended for admission to hospital for investi-
8 gation and treatment. Let us assume that tuberculosis
9 is established. We now have drugs, so-called miracle
10 drugs which are very effective against tuberculosis.
11 We put out a fire by smothering with water and we put
12 out tuberculosis by smothering the tubercle bacilli
13 with chemicals.

14 Now, this, as with a fire, is much
15 easier to put out a small fire in the wastepaper basket
16 than a whole house afire and so it is important that we
17 diagnose tuberculosis in the early stage because the
18 results are still much better and more certain if we get
19 it at an early stage.

20 Now then, at the present time you
21 would stay in a tuberculosis hospital, perhaps on the
22 average - there is no such thing as an average patient
23 but the average stay would be approximately seven
24 months whereas about six years ago it would be 18 months.

25 Now, you have been discharged then
26 continue with drug treatments following your discharge.
27 In fact, you may even return to work shortly after
28 discharge and continue at work while taking these drugs.

29 The total duration of treatment now is
30 still 18 months to two years but the stay in hospital is



1 much shorter. Mind you, treatment is still continuing
2 but it is in the post-sanatorium stage at home.

3 Now, it seems a paradox, Mr. Chairman,
4 that perhaps some of our success has resulted in some
5 of our problems today. One of our main problems, I
6 think, is the complacency and indifference of the public
7 towards this disease.

8 For instance, as you may know, our
9 Association is composed of volunteer workers, medical
10 and non-medical and our charter dates back to 1900.
11 A great many changes have taken place in the tuberculosis
12 picture since that time.

13 For instance, if this Commission were
14 sitting 30 or 40 years ago we would be asking you to
15 help us control tuberculosis among cattle, provide more
16 sanatoria beds for the long waiting list.

17 Now, this is not so today, no longer
18 does tuberculosis affect or strike one member of almost
19 every family in our land, no longer do we have a long
20 waiting list for admission to tuberculosis hospitals.

21 Now, there are some who say that tuber-
22 culosis is under control in this country of ours. Well,
23 I think we will admit that tuberculosis is perhaps not
24 out of control only we read occasionally of reports in
25 certain locations where it might appear that tuberculosis
26 could become temporarily out of control.

27 Now, controlling this is a matter of
28 degree and I would like to perhaps bring before you a
29 standard set by the World Health Organization for the
30 control of tuberculosis.



1 This standard states that no child at
2 school-leaving age, about 16 years of age, or not more
3 than 1% of such children, shall be positive to tubercu-
4 losis, not more than 1% at 10 years of age shall be
5 positive to tuberculosis.

6 We do not know of any country in the
7 world or any province in Canada that has achieved that
8 standard as yet. I would submit, Mr. Chairman, that
9 tuberculosis is under control only to a degree in our
10 economy.

11 For instance, in 1960 there were 9,500
12 persons admitted to our tuberculosis hospitals and the
13 treatment cost alone, exclusive of federal institutions,
14 was approximately \$34,000,000. This, of course, would
15 not by any means represent the total cost of this
16 disease to Canada; it does not include the time lost
17 from gainful employment; it does not include the assis-
18 tance to families where the breadwinner is under treat-
19 ment; it does not include the best sanatorium care.

20 I think if I might draw one more illus-
21 tration and perhaps help you to understand; I like to
22 think of two pictures side by side, one picture shows
23 100 cows and perhaps in pasture in this land of ours
24 and under this picture is the caption "No Tuberculosis
25 Here, No Tuberculosis Infection Here".

26 The other picture is 100 people selected
27 at random from almost any street in any city of our
28 country, 100 people, and under that picture there will
29 be "30% of These People Harbour the Tubercle Bacilli".
30



1 Now Mr. Chairman one other problem, one
2 other unsolved problem that faces our people is the
3 need for more basic research in tuberculosis. You
4 see, at the present time our plan for the control of
5 tuberculosis depends upon the cooperation of the
6 public. The cooperation of the public in accepting
7 our invitation to have regular examinations to detect
8 early tuberculosis.

9 Because of the complacency towards this
10 disease, there is some indication that the public may
11 not be responding as well as they should to our oft
12 repeated invitations and so perhaps what we need is
13 a once and for all gimmick, if I may use that word.
14 Perhaps a more effective vaccine or a new miracle drug.

15 Now to obtain these two important advances,
16 we need more basic research.

17 Another problem, if I may dwell briefly on
18 it, is the development of resistance to the drugs which
19 we have available for the organisms which cause this
20 disease. I think you are familiar with the development
21 of resistance of some of the other organisms,
22 streptomycin and so on, to penicillin. This doesn't
23 take place so rapidly with tuberculosis but there is
24 some evidence to indicate that the tubercle bacilli
25 may be developing an increasing degree of resistance
26 to the drugs which we have available. The study
27 which we hope to commence in Canada shortly will
28 perhaps give us some accurate figures on this point.

29 The danger is of course that if an individual
30 is excreting tubercle bacilli which are resistant to the



1 three drugs, he will produce tuberculosis to another
2 individual with those germs and then our attempts to
3 treat that individual with our drugs will be unsuccessful.

4 In other words, we will be back in the pre-
5 miracle days, pre-miracle drug days in so far as
6 that individual is concerned. If this increases at
7 a rapid rate, we may be in for trouble unless, of course,
8 we find another drug so it is important that the
9 public be kept aware of these facts and it is
10 particularly important that we have the means of
11 carefully supervising patients when they leave hospital
12 because it is the person who takes his drugs irregularly,
13 who drops his drugs for some reason for a few days
14 or a week. It is in those instances where the
15 tubercle bacilli develops resistance to the drug.

16 It is important that patients, released
17 patients be supervised and required to take their
18 treatment regularly and consistently.

19 Finally, Mr. Chairman, there is just one
20 other unsolved problem I would like to mention and
21 that is the problem of convincing those who are in
22 charge of expenditure of funds for official agencies
23 that the money that is being saved by the shorter
24 duration of treatment in the hospital, we feel some
25 of that money should be expended to provide treatment
26 services outside of hospital.

27 We would like to see some of the money
28 saved reinvested to provide adequate followup and
29 careful supervision in this period of treatment that
30 now takes place after the period in hospital. I think



1 this is very important.

2 We might say that -- I don't think we know
3 as yet the exact ratio -- but let us say for every
4 ward closed in a tuberculosis hospital provision
5 should be made for the treatment and supervision of those
6 patients displaced from the ward in their homes.

7 I think Mr. Chairman I may have perhaps said
8 enough to convince you that there are still some
9 unsolved problems in tuberculosis. Thank you.

10 THE CHAIRMAN: Thank you very much Dr. Wicks
11 not only for the brief but for your comments which have
12 been very educational, certainly to me. Dr. Van Wart.

13 COMMISSIONER VAN WART: In item No. 13
14 you state that the hospital cost for treatment in 1950
15 was \$22 million and 1960 \$33 million. This is in a
16 hospital that is not under the hospital insurance plan.
17 Is that not correct?

18 DR. WICKS: This is the cost of operating
19 all provincial institutions throughout Canada and I
20 believe that federal funds are not available for
21 this work.

22 THE CHAIRMAN: Tuberculosis is excluded under
23 the Act?

24 DR. WICKS: Yes sir.

25 COMMISSIONER VAN WART: Does the percentage
26 of increase parallel a percentage of increase in
27 hospitals that are under the hospital plan?

28 DR. WICKS: Maybe Dr. Jeares would like to
29 take a stab at that.

30 DR. JEANES: If I understand your question:



1 is the increase due to the general overall cost of
2 services?

3 COMMISSIONER VAN WART: Well what I was
4 aiming at: is this increase less than you would
5 expect in a hospital under the scheme, insurance
6 scheme or is it parallel with it or more than?

7 DR. JEANES: I think it is parallel but
8 of course tuberculosis hospital costs are much lower
9 than general hospital costs.

10 COMMISSIONER VAN WART: But the increase
11 is parallel?

12 DR. JEANES: The increase is parallel, yes.

13 COMMISSIONER VAN WART: We are hearing that
14 over-utilization is one of the causes of the increased
15 cost under the scheme. Then your scheme is under-
16 utilization. You are not utilizing the services as
17 much under costs which parallel?

18 DR. JEANES: Yes. If you have ten empty
19 beds, empty in a hospital, it does not reduce the cost
20 all that much. It will cost the same amount for
21 heating services and pathology services so that
22 because a hospital has a small number of empty beds
23 it does not reduce its cost by 50 per cent by any means.

24 COMMISSIONER VAN WART: But if the beds were
25 occupied the cost would be larger?

26 DR. JEANES: Occupied by tuberculosis patients?

27 COMMISSIONER VAN WART: Yes.

28 DR. JEANES: Yes, oh yes.

29 COMMISSIONER VAN WART: Turning to No. 19 you
30 state:



1 "In some institutions
2 Canadian-born physicians constitute
3 not more than 25 per cent of the
4 medical staff."

5 Have you any explanation for that?

6 DR. JEANES: It does seem that young Canadian
7 graduates feel, like the general public, that
8 tuberculosis is a disease that will not provide them
9 with a life's work and therefore they do not show any
10 interest in it. The medical students are having
11 less and less opportunity of being brought into
12 contact with cases of tuberculosis and therefore their
13 interest is not being developed so that this is the
14 pattern right across the country; that very very few
15 young Canadian graduates are showing any interest in
16 tuberculosis work.

17 COMMISSIONER VAN WART: Is there any financial
18 consideration?

19 DR. JEANES: I am sure this is a factor in
20 that the salaries paid to the tuberculosis staff were
21 mostly, for full time people, considerably lower than
22 the average medical salaries.

23 COMMISSIONER VAN WART: Do you have difficulty
24 in retaining foreign doctors in your institution on
25 account of salary?

26 DR. JEANES: Yes, I think this is so. What
27 very often happens, they come and stay for two or
28 three years during which time they practice. They take
29 their Dominion council examination, and then they tend
30 to find their own feet and go out into some other sort



1 of medical practice.

2 COMMISSIONER VAN WART: Coming now to
3 section 22 you develop the arguments that the
4 tuberculosis hospitals should be kept for tuberculosis
5 patients. Is there not a possibility of you using
6 the space in the tuberculosis hospitals for non-
7 tuberculosis chest conditions; develop such a service?

8 DR. JEANES: I think there is, yes. Some
9 of the old sanatoria are not suitable for this.
10 Their buildings are physically unsuitable or they are
11 unsuitable because of their isolation. The old
12 tradition, as you know, the sanatorium had to be far
13 away from the city but the sanatorium, the more modern
14 sanatorium, particularly where they are well situated
15 geographically could well be used for this purpose.
16 Of course the advantages of this would be that it would
17 increase the interest of the medical and nursing staff
18 and it is much easier to retain staff when they have
19 got wider interest.

20 COMMISSIONER VAN WART: Is it not true in
21 your x-ray survey that a majority of disease findings
22 are non-tuberculosis that you found in the chest?

23 DR. JEANES: Yes. That is true. Many other
24 conditions are found on mass x-ray surveys.

25 COMMISSIONER VAN WART: Then the service in
26 a tuberculosis hospital could very well accommodate
27 many of these people?

28 DR. JEANES: Yes, and of course this has
29 developed already in a few places in Canada very
30 satisfactorily.



1 COMMISSIONER VAN WART: That is all Mr. Chairman.

2 COMMISSIONER BALTZAN: Gentlemen I am not
3 going to ask you any question about medicine. Not
4 that I have the answers but I would like to confine
5 myself to one or two things here. In paragraph 2 you
6 state:

7 "Although maintenance of
8 tuberculosis hospitals is
9 now the responsibility of the
10 provincial governments, the
11 direction of many of these hospitals
12 is still in the hands of voluntary
13 boards."

14 My question is: in the past and up to now do you find
15 that a happy combination when you have both Government
16 to establish the interests and the direction of
17 voluntary boards?

18 DR. JEANES: Yes. My President's sanatorium is
19 one by a voluntary board and this is the pattern
20 throughout the Province of Ontario. This does seem to
21 be a very happy combination.

22 I think one of the great advantages of the
23 voluntary board is that it tends to make local people
24 interested. They feel well this is our hospital and
25 it does breed a very good spirit.

26 COMMISSIONER BALTZAN: A little bit cheaper
27 too?

28 DR. JEANES: Well it is said so.

29 COMMISSIONER BALTZAN: Thank you. I suppose
30 you would like to see that combination prevail?



1 DR. JEANES: We would.

2 COMMISSIONER BALTZAN: Voluntary interest
3 continue?

4 DR. JEANES: Yes. I am quite convinced that
5 the strength of the tuberculosis program in Canada
6 has been built up by this combination of the Government
7 and voluntary board and they do seem to work extremely
8 well together and it would be sad to see it destroyed.

9 COMMISSIONER BALTZAN: That answers my question.
10 Thank you.

11 Paragraph 4 only in connection with the mention
12 of drugs. What is the average cost of maintenance
13 therapy on the out-patient basis? Ambulatory. What
14 is the daily cost or yearly cost or monthly cost to
15 the individual?

16 DR. WICKS: Mr. Chairman, I am afraid I cannot
17 answer that question without referring to some further
18 or other information. First of all, the average cost
19 of treating a patient in our hospital is approximately
20 \$11.00 per day.

21 COMMISSIONER BALTZAN: Excuse me, I am talking
22 about drugs.

23 DR. WICKS: The cost of drugs, or providing
24 drugs to patients after they leave hospital -- I am
25 sorry, I cannot answer this question accurately but
26 I would just like to point out: it depends to a large
27 extent, of course, on whether those drugs are provided
28 to the patient through the Provincial governments
29 who obtains federal health grants because they can
30 purchase these drugs at a very low cost. Whereas,



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1 if the patient has to pay himself, the cost is many
2 times multiplied. I think we can get that information
3 for you.

4 DR. JEANES: I would suggest it is of the
5 order of \$100.00 a year for a full course of the drugs
6 which is streptomycin PAS and isoniozid.

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1 COMMISSIONER McCUTCHEON: Is that bought
2 at retail?

3 DR. JEANES: No, I was referring to this
4 bulk buying. Most of the patients receive free drugs
5 at the sanatoria. I don't think patients buy their
6 tuberculin drugs.

7 COMMISSIONER BALTZAN: Those free drugs
8 are available to patients on the basis of this being
9 a provision through voluntary contributions?

10 DR. JEANES: No, drugs are provided by
11 voluntary contributions, they are provided the Department
12 of Public Health. It is a provincial responsibility.

13 COMMISSIONER BALTZAN: There are some who
14 buy it through retail?

15 DR. JEANES: Yes.

16 COMMISSIONER BALTZAN: You can't tell us that
17 cost?

18 DR. JEANES: No.

19 COMMISSIONER BALTZAN: You mentioned about
20 people who avail themselves of the provision of
21 screening examinations and difficulty -- you bring, shall
22 we say, the horse to the trough. Here you have an
23 example of available examinations and resistance to
24 avail themselves of the opportunity.

25 DR. JEANES: That is so.

26 COMMISSIONER BALTZAN: Is there any
27 explanation, because we hear so much of routine
28 examinations, if this were available it would be a
29 wonderful thing for the health of the people, etc. Here
30 you have this and the opportunity is not taken.



1 DR. JEANES: No. If you work moderately
2 hard on the organization to get people to come you may
3 get forty per cent of the adult population to attend,
4 and in order to get it to 60 per cent or 80 per cent
5 you have to work very hard and set up a committee and
6 do house to house canvassing and then you will get
7 60 per cent to 80 per cent. But a lot of the work
8 can easily be a failure. I think the public are
9 complacent -- tuberculosis is a disease which doesn't
10 happen any more in Canada, they don't bother to go.
11 It is complacency on the part of the public. It is
12 a very sad thing that we are still picking up advanced
13 cases of tuberculosis.

14 COMMISSIONER BALTZAN: Is it more in older
15 age bracket?

16 DR. JEANES: Yes, it is very much a disease
17 in older men.

18 COMMISSIONER BALTZAN: One last question, and
19 that is there is a current belief, things that people
20 read, that repeated x-ray examinations have a
21 deleterious effect, and sometimes when you ask them to
22 be re-examined, have another x-ray -- to what extent
23 would this influence, make that fear?

24 DR. JEANES: Two or three years ago when
25 the scare was at its height I think people used that
26 as an excuse for not having surveys, but we have
27 not had that excuse lately. One could have up to
28 one hundred chest x-rays before you could even approach
29 the danger.

30 COMMISSIONER BALTZAN: In other words, it is



1 public about tuberculosis. We are at the moment on
2 a new project which we are just starting. We are
3 making a film for a public showing about tuberculosis.
4 But we have a director of health education, Miss
5 Grant, who is fully engaged in disseminating this type
6 of information right across Canada.

7 COMMISSIONER STRACHAN: Referring back to
8 these advanced cases, after they are found do you find
9 that they have recognized these symptoms but have
10 paid no attention? Were they aware of the symptoms
11 of advanced tuberculosis?

12 DR. WICKS: I think it is true that some
13 people do ignore these symptoms, and I think this is
14 one of the important points and one of the important
15 duties of our association, to make this information
16 available to the public, that they should first of
17 all have regular examinations while they feel perfectly
18 well, because this is when we can discover tuberculosis
19 in the early stage before it can be transmitted to
20 others. But lacking that, certainly to recognize these
21 symptoms and seek medical care.

22 COMMISSIONER GIRARD: Dr. Wicks, how
23 widespread is the use of BCG vaccine throughout Canada?

24 DR. WICKS: Mr. Chairman, BCG vaccine has
25 proved its usefulness; there is no question that
26 BCG vaccination does provide some degree of immunity
27 against tuberculosis. The difficulty is that it
28 causes the person to become a tuberculin reactor, and
29 to some extent this tends to nullify the benefit of
30 tuberculin testing. For instance, if five years ago



1 not substantiated, not too well founded.

2 DR. JEANES: No.

3 COMMISSIONER BALTZAN: Thank you very much.

4 COMMISSIONER STRACHAN: You have just
5 mentioned these advance cases which are found in the
6 surveys. Are there any symptoms which the public might
7 observe, the individual might observe, similar to
8 what is given out regarding cancer?

9 DR. JEANES: The symptoms of tuberculosis
10 are cough, bringing up phlegm, loss of weight.
11 These are the principal symptoms. Unfortunately the
12 type of individual who doesn't go to a survey may
13 well have these symptoms from other conditions; he
14 may have a lower standard of living, his condition is
15 poor, and unfortunately alcoholism plays a part in
16 tuberculosis. So one has a particular social
17 background of even --

18 COMMISSIONER STRACHAN: Nothing specific.

19 DR. JEANES: There are specific symptoms
20 of tuberculosis, but they are not sufficiently dramatic
21 to make the person who doesn't care very much do
22 anything about it.

23 COMMISSIONER STRACHAN: Can anything be
24 done in the way of public information as regards drugs,
25 for instance?

26 DR. JEANES: Well, this is perhaps one of
27 the greatest parts of the program of the voluntary
28 tuberculosis association, the Canadian Tuberculosis
29 Association and the ten associations; the greatest
30 part of our program is public education, educating the



1 we had recommended BCG vaccination of all children,
2 then today we would be faced with a population of
3 five year olds, many of whom would have a positive
4 tuberculin reaction and we would be unable to say
5 whether it was due to the BCG vaccine or infection
6 by tuberculin bacilli. And also in Canada there is
7 some hope that with our decreasing incidence of
8 tuberculosis many of the children born today will not
9 meet the tuberculin bacillus. In other words, when
10 you are living in a community where there are no thieves,
11 then it is not necessary to lock the door, but when
12 you are living in a community where there are thieves,
13 then you have to lock the stable door. In Japan,
14 elsewhere, The World Health Organization recommends
15 that these children be vaccinated with BCG vaccine,
16 but in Canada, partly because we hope our children born
17 today, not many may require or be challenged by the
18 bacillus and partly because it causes the children to
19 become positive reactors, we have limited it to the
20 following groups: (a), contacts with known cases of
21 tuberculosis and positive reactors; (b) persons, by
22 reason of their employment, are almost certainly to
23 be infected, nurses, doctors, technicians, and also
24 people who are living under conditions who might be
25 heavily infected, such as native North American Indians
26 or people in the armed forces who are likely to be
27 posted to places where there is tuberculosis.

28 COMMISSIONER GIRARD: Even although there
29 are no more thieves, we still have people who have
30 tuberculosis, so you are taking a chance, there may be



1 contact. You are taking a chance because the
2 tuberculosis incidence is going down.

3 DR. WICKS: As you say, it is a calculated
4 risk. Of course, if we had a vaccine that would
5 produce complete immunity, and particularly if this
6 vaccine would not cause the person to become a positive
7 reactor, that is what we mean.

8 COMMISSIONER GIRARD: That is what you need
9 money for?

10 DR. WICKS: Yes.

11 COMMISSIONER GIRARD: Another point. The
12 home conditions are good and the case does not warrant
13 special treatment. Do you still insist on having this
14 case hospitalized?

15 DR. WICKS: This is a question that is in
16 the minds of many people today. I think that many
17 of us were prepared years ago to accept that there
18 were certain patients, certain persons who were
19 intelligent and cooperative and where there were no
20 children in the home and where they could provide
21 excellent medical nursing and supervisory care they
22 could perhaps create a sanatorium in their own homes,
23 and this was quite satisfactory. I think most of us
24 would agree that at the present time the number of
25 persons with tuberculosis who could be cared for at
26 home has increased. But we still believe that there
27 is a great deal to be gained by hospital admission,
28 initial hospital admission of the patient on the first
29 diagnosis of suspected tuberculosis, because I think
30 it is important first of all to establish and to



1 confirm that it is tuberculosis that we are treating.
2 One of the difficulties, of course, is the institution
3 of treatment for tuberculosis; the drugs are effective,
4 the x-rays shadows resolved, and if inside two or
5 three months we find that the shadows have resolved,
6 we might say this is an excellent result in the
7 treatment of tuberculosis. But this could be
8 something else than tuberculosis, and once we start
9 the treatment we should continue it for eighteen
10 months so we can make sure it is tuberculosis.
11 Secondly, we agree that the patient should be given
12 some instruction, and this is one of the things that
13 can be accomplished in the hospital, because the
14 patient should be informed about the cavity condition,
15 and so on, and the dosage of drugs can be adjusted.
16 Thirdly, the discharge of the patient at a time when,
17 in the opinion of the attending physician, this is
18 in his best interest and in the interest of public
19 health. I said the average stay in tuberculosis
20 hospital today was six or seven months. I stressed
21 that there was no such thing as an average patient.
22 Dr. Jeanes referred to the alcoholic. We recommend
23 that they stay much longer than seven months, because
24 we doubt their ability and their cooperation to take
25 the drugs conscientiously after discharge.

26 COMMISSIONER GIRARD: One more question, Dr.
27 Wicks. On page 6, paragraph 16, the last three lines
28 that read:

29 "The rate of reactivations in
30 ex-patients is from twenty to thirty



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1 times that of the rate of new
2 cases appearing in the rest of the
3 population".

4 Would you say that this is due to the lack of followup
5 or the poor followup procedures?



1 DR. WICKS: I think that most of us would
2 agree that some of the patients who have their disease
3 reactivated, in certain cases this is due to, well,
4 many factors. First, as you mentioned, perhaps
5 inadequate post-sanatorium care but, and in some
6 cases too, to the fact that these patients discontinue
7 their drugs, but I agree that in most instances, or
8 in many instances, it is because the cake was not
9 baked thoroughly the first time, and in many instances
10 these patients, some of them, not all, but some of
11 them left the tuberculosis hospital before the cake
12 was baked.

13 COMMISSIONER GIRARD: But what are the
14 follow-up procedures from the sanatorium?

15 DR. WICKS: Mr. Chairman, when a patient
16 is discharged from our tuberculosis hospital, and I
17 think this applies to all tuberculosis hospitals,
18 they are given careful information by the attending
19 physician and by the admitting and social service
20 nurse, and it is explained to them the importance of
21 continuing with their drug treatment. And their
22 home conditions are investigated. As a matter of
23 fact, in Ontario, and I believe this is true in many
24 of the other provinces, the patient is not discharged
25 until we have a report from the medical officer of
26 health that the soil has been prepared for the return
27 of this patient. The public health nurse visits the
28 home, and then she reports back to the hospital, and
29 we discharge the patient only when we have a favourable
30 report upon the home conditions.



1 COMMISSIONER GIRARD: Is this enough?

2 DR. WICKS: I think, Mr. Chairman, this is
3 the crux of the situation. I don't think at the
4 present time that we have personnel spending enough
5 time observing these people and supervising them and
6 helping them to continue with their treatment. This we
7 would like to see very much.

8 COMMISSIONER GIRARD: Do you believe it would
9 be less costly to have more follow-ups than to have
10 twenty to thirty times more re-admissions?

11 DR. WICKS: Mr. Chairman, we agree.

12 COMMISSIONER FIRESTONE: In paragraph 6
13 of your recommendations you say that hospitalization
14 of tuberculosis should be included in hospital insurance
15 plans in the provinces, and you elaborate this point
16 subsequently in paragraph 22, and offer some comments
17 about federal grants in this connection in paragraphs
18 24 to 26. Do you have in mind in this recommendation
19 6 that the Federal Government should contribute to
20 such provincial programs?

21 DR. JEANES: Yes, I think this is the
22 suggestion in these proposals.

23 COMMISSIONER FIRESTONE: As both you
24 gentlemen are aware, the Hospital Insurance and
25 Diagnostics Act, specifically excludes federal contributions
26 to provincial schemes for tuberculosis hospitals. Would
27 you therefore be in favour of an amendment of this
28 legislation, to provide for such federal participation?

29 DR. JEANES: Well, the federal health grants
30 for tuberculosis have been so successful that I think



1 the answer is yes.

2 COMMISSIONER FIRESTONE: This being a Royal
3 Commission advising the Federal Government, if we were
4 to make such a proposal, we would have to present
5 specific reasons why we would so recommend. Could
6 you offer some advice what the specific reasons would
7 be ~~for the~~ Federal Government to make that financial
8 contribution, and I would like to suggest to you four
9 possible reasons. You may agree or disagree, or you
10 may have some others.

11 Would you say that one advantage would be
12 better services; secondly, perhaps increased coverage;
13 three, greater economy; four, financial equity.

14 We must have some specific reasons why we
15 would want to put such a proposal forward to the
16 Federal government. Can you offer us some views?

17 DR. JEANES: I think your points are four
18 excellent ones, and they could be reinforced by the
19 success of the federal health grants for tuberculosis,
20 and I think this is the great example of a very
21 successful federal-provincial cooperation. The
22 federal grants have made a great extension of
23 tuberculosis services possible.

24 COMMISSIONER FIRESTONE: But you see, sir,
25 if this program is already working well, what are the
26 reasons for recommending changes in existing legislation?

27 THE CHAIRMAN: That is your tuberculosis
28 program?

29 COMMISSIONER FIRESTONE: Yes, thank you,
30 Mr. Chairman.



1 DR. JEANES: The service is working well, but
2 there is a certain difference in the standard of
3 service provided in parts of Canada, and if you have
4 some unification, we hope that the standard would be
5 raised in places where we would feel it is not as
6 high as we would like.

7 COMMISSIONER FIRESTONE: So another reason
8 would be the raising of the standards, in addition to
9 the other four reasons that have been mentioned?

10 DR. JEANES: Yes.

11 THE CHAIRMAN: Dr. Wicks and Dr. Jeanes, we
12 are very grateful to you for your presentation here
13 this morning. I think I perhaps should mention that
14 the Commission has singled out tuberculosis as one
15 of the subjects to which it is giving study, and as
16 you may know Dr. Wherrett is doing the study for the
17 Commission, and your presentation here this morning
18 will naturally be placed at his disposal, as well as
19 the other material that has been accumulated and got
20 together, both by him and the research staff.

21 Thank you very much.

22 DR. WICKS: Mr. Chairman and members of the
23 Commission, I would just like on behalf of our
24 Association to thank you very much for your interested
25 and courteous hearing.

26 THE CHAIRMAN: Now we will recess to
27 a quarter past two.

28 ---Luncheon adjournment.
29
30



/dpw 1 --- On resuming at 2.15 p.m.

2 THE CHAIRMAN: Yes, Mr. Hall?

3 MR. HALL: Mr. Chairman, the next submission is that of the Great-West Life Assurance Company
4 and the Metropolitan Life Insurance Company and I would
5 suggest this submission be filed as Exhibit 200.
6

7
8 --- EXHIBIT NO. 200: Submission of The Great-West Life
9 Assurance Company and Metropolitan
Life Insurance Company.

10 SUBMISSION OF THE GREAT-WEST LIFE ASSURANCE

11 COMPANY AND METROPOLITAN LIFE INSURANCE

12 COMPANY

13 Appearances: David E. Kilgour
14 Gilbert W. Fitzhugh
15 George Berry
Cecil White

16 MR. KILGOUR: We have submitted our
17 submission to the Commission and would it be your wish
18 I should read it or have you had the opportunity to look
19 at it?

20 THE CHAIRMAN: We have had an opportunity
21 to look it over but it is short and you might read it.

22 MR. KILGOUR: My Lord and Members of the
23 Commission:

24 We appreciate the opportunity of appearing
25 before the Royal Commission today. We represent two life
26 insurance companies, The Great-West Life Assurance Company
27 and the Metropolitan Life Insurance Company. Together we
28 are providing health insurance in some form for nearly
29 1,530,000 Canadians, and our business represents approxi-
30 mately 23% of all the health insurance business in force



1 with licensed insurers in Canada.

2 Both of our companies write both group
3 and individual policies; many companies issue one or the
4 other but we issue both.

5 THE CHAIRMAN: When you say health
6 insurance, would you define what is included in health
7 insurance?

8 MR. KILGOUR: My definition would be,
9 I think, all forms of insurance in which the contingency
10 insured against is related to the health of the applicant
11 as distinct from life insurance where the contingency is
12 a date or death, maybe weekly, indemnity medical forms,
13 any variation in which the contingency fundamentally
14 insured against is some aspect of health.

15 The Great-West Life is a stock company
16 incorporated by Act of the Canadian Parliament in 1891.
17 Its home office is in Winnipeg. It is the largest
18 Canadian insurer in the health insurance field.

19 The Metropolitan Life is a mutual
20 company incorporated in 1868, and is the largest insu-
21 rance company in the world, with its home office in New
22 York City. It has been serving Canadians since 1872
23 and has had a Canadian head office here in Ottawa since
24 1924. It provides health insurance protection for more
25 Canadians than any other single company.

26 At your Halifax Hearings the Canadian
27 Health Insurance Association, of which we are members,
28 made a brief presentation indicating that a more complete
29 submission would be made later. This, we understand,
30 will be presented at your Hearings in Toronto in May.



1 Our appearance today is not on behalf
2 of the Association, although it is made with its full
3 knowledge and concurrence. It is therefore not our
4 purpose nor would it be proper for us to present any
5 statement or comments on the Association's proposed
6 presentation. We are here as two of the leading compa-
7 nies to make available to the Commission our relatively
8 long and extensive experience in the field of insuring
9 Canadians against the hazards of accident and illness,
10 and to assist the Commission in any way that we can.

11 Up to the present time there has been
12 a good deal of testimony before the Commission on the
13 subject of Compulsory Government Health Insurance of one
14 form or another, and comparatively little evidence with
15 respect to the role of voluntary health insurance as
16 provided by the insurance companies. Some of the refe-
17 rences to voluntary insurance indicate a lack of under-
18 standing both of its role and of the operations of
19 insurance companies. It seemed to us it might be helpful
20 to the Commission if we made a brief statement about the
21 role of insurance companies in this field, what they do
22 and do not do, the important part voluntary insurance
23 plans have played in providing these forms of protection
24 to Canadians, and the advantages of retaining and encou-
25 raging voluntary systems of health insurance to help
26 finance health care.

27 Our presence today will also, we hope,
28 give you an opportunity to ask about some of the aspects
29 of voluntary health insurance where you believe we might
30 be helpful.



1 It may be trite to say so but the basic
2 characteristic of the coverage which we provide is that
3 it is voluntary.

4 This means that no one is compelled to
5 buy it if in his wisdom he chooses not to do so and, as
6 will be apparent from figures furnished to the Commission
7 in earlier testimony, many Canadians financially able to
8 do so have so far chosen to carry this risk themselves
9 and employ their available funds for other purposes. As
10 insurers we may deplore this decision and question its
11 wisdom, but we support the right of those individuals
12 to make that decision for themselves.

13 The voluntary system also means that
14 the individual is free to buy what he feels he needs or
15 what he feels he can afford. It is perhaps in this area
16 that the insurance companies with their long experience
17 in providing specialized protection have a particular
18 role. The great growth which there has been, for example,
19 in the field of life insurance has undoubtedly been due
20 in very large measure to the ability of the companies to
21 provide plans designed to meet the most common needs and
22 to modify these plans where necessary to deal with
23 special situations. This same flexibility is available
24 in the health insurance field from voluntary health
25 insurers. Being life insurance companies, we have perhaps
26 naturally used the analogy of life insurance, but we
27 believe similar examples could be furnished from other
28 insurance fields.

29 In a word, the voluntary system permits
30 tailoring coverage to the needs and purse of the individual



1 Canadian and his family.

2 This leads to a comment on the difference
3 between insurance and budgeting. It is not the primary
4 purpose of insurance to provide protection against small
5 expenses in the field of health care. It is more effi-
6 cient and economical for the individual to take care of
7 these expenses himself, just as he does for example the
8 costs of such things as food and clothing. The primary
9 purpose of health insurance, like that of other forms of
10 insurance, is to substitute the payment of a relatively
11 small regular premium for the risk of large unpredictable
12 losses, in this particular case heavy health care costs.

13 Striking illustrations can be provided
14 to demonstrate the extent of the additional coverage
15 that can be provided for more serious illnesses for the
16 same premium dollar under plans which exclude payments
17 for minor bills which normally might be budgeted for by
18 the family as compared with plans which include such
19 small payments.

20 Inevitably there are going to be cases
21 (although perhaps not nearly so many as some have
22 suggested to you) where the purse will be insufficient
23 to provide fully for a family's reasonable needs.
24 Traditionally this problem has been met by the providers
25 of medical care -- that is, the doctors -- making their
26 services available either without charge or on a reduced
27 fee basis. More recently, in the treatment of the truly
28 indigent, successful arrangements have been evolved in
29 certain provinces for the sharing of this responsibility
30 between governments and the profession. Other



1 arrangements may be required for the marginal group
2 which cannot be classed strictly as indigents but where
3 the purse is in fact inadequate to provide for reasonable
4 needs. Conceivably with this latter group government
5 may have some greater part to play. What part should
6 be played by government and what part by the profession
7 is not for us as insurers to say. We can however as
8 insurers offer our services to whatever extent we may
9 be found helpful.

10 Few personal relationships require
11 greater mutual confidence and are closer than the rela-
12 tion of a patient to his physician. It is, in consequence,
13 of the utmost importance to provide and preserve an
14 atmosphere in which the two parties may freely and
15 directly form, continue, or terminate this particular
16 relationship.

17 Our primary role as insurers in the
18 health care field is to provide a flexible and comprehen-
19 sive financing mechanism to assist our policyholders in
20 meeting the costs of necessary medical and other care
21 for themselves and their dependants. This mechanism
22 should be, and in our view is, capable of providing this
23 assistance not only for existing needs but also for
24 those arising in the future, as new skills, new treat-
25 ments and procedures are evolved by the providers of
26 health care.

27 Responsibility for improvement in the
28 standards and quality of health care properly belongs
29 primarily to the providers of that care. As insurers,
30 it is our responsibility to design our insurance plans



1 so that their operation does not adversely affect
2 medical standards or quality, and to do everything we
3 properly can to encourage the continued improvement in
4 such standards and quality.

5 In summary, the advantages of the
6 voluntary system include -

7 1. For the individual:

8 (a) The right to choose the proper plan
9 for him from the very wide range of
10 plans designed to meet every type of
11 need, or to reject all and buy none.

12 (b) The freedom to select the insurer
13 and the method of financing, i.e.,
14 insurance or prepayment.

15 (c) The freedom to select and to
16 change his doctor.

17 (d) The right to enjoy the benefits
18 accruing from the competition between
19 the different insurers.

20 2. For the providers of health care:

21 (a) It maintains the doctor-patient
22 relationship.

23 (b) It does not interfere in the prac-
24 tice of medicine, and it preserves the
25 proper atmosphere to permit the factors
26 leading to improvement in the standard
27 and quality of care to operate freely.

28 The voluntary health insurance systems
29 have made great strides in providing Canadians with
30 various forms of medical care coverages. Progress in



1 the development of new and broader developments and
2 improvements in service to policyholders have been
3 stimulated by the presence of many competing prepaid
4 plans and insurers. Equally competition, by giving
5 the customer a wide range of plans to choose from, has
6 compelled all insurers to strive to provide these
7 coverages at the lowest cost consistent with the benefits
8 and services provided.

9 We hope what we have said will be of
10 help to the Commission. We shall be happy to answer any
11 questions which you may have on these points or any other
12 phases of the health insurance field. Thank you for
13 giving us this opportunity to appear before you.

14 THE CHAIRMAN: Thank you. I think
15 members of the Commission have a number of questions
16 which they would like to put and some of these may well
17 range, as you, I think, have anticipated, beyond the
18 scope of what you have covered in this memorandum.

19 MR. KILGOUR: We will be very happy to
20 have the questions put.

21 THE CHAIRMAN: Perhaps, reaching directly
22 to what may be a question that is fundamental to what
23 you have said here this afternoon, you have gone to some
24 trouble to explain the benefits received by insured
25 individuals through the existing voluntary insurance
26 policies as a whole. Will you tell us why these benefits
27 should not be extended to the entire population by intrc-
28 ducing a government program that will automatically cover
29 everyone?

30 To put it another way, what are the



1 advantages, if any, of maintaining voluntary competitive
2 systems as against all others?

3 MR. KILGOUR: If I could speak first
4 I am sure Mr. Fitzhugh will want to add something and
5 express a different viewpoint.

6 I know that my own fundamental objection
7 to a comprehensive government plan is that it must be
8 compulsory and therefore it creates a monopoly. In my
9 judgment a monopoly in such an important field as health
10 services could not be more damaging to the long-term
11 interest of Canadians.

12 The voluntary system is spreading
13 rapidly, dynamically flexible. We have in many, many
14 areas a substantial portion of the people who have bought
15 such plans; we have another group that choose not to buy
16 them and it is their own wisdom if they conclude to
17 carry the expenses of medical care themselves as they do
18 other fields of their expenses.

19 I feel on that score that the monopoly
20 which a government system must include is the dramatic
21 danger point on which such a scheme would, in fact,
22 break down the health care of Canadians rather than
23 adding to it.

24 THE CHAIRMAN: You base that on this
25 proposition that there is an option on the individual
26 to buy or not to buy?

27 MR. KILGOUR: And to go to the doctor
28 he wants to go or not to go if he so wishes and to
29 change doctors. He has all the freedom of the market
30 place today.



1 THE CHAIRMAN: Supposing he has not
2 the wherewithal to exercise that option?

3 MR. KILGOUR: In a sense an indigent?

4 THE CHAIRMAN: An indigent or dependent
5 on the market place of the product that you say you have
6 to sell.

7 MR. KILGOUR: Well, in that sense if
8 we speak of someone with no money the medical profession
9 and our hospitals all traditionally looked after those
10 people with excellent medical care.

11 THE CHAIRMAN: Mr. Fitzhugh, do you
12 wish to add something to what Kilgour said?

13 MR. FITZHUGH: I think Mr. Kilgour
14 has covered it quite well. I think that I would like
15 to add a couple of items and stress this business of
16 your particular question as to whether it is good for
17 the people through the voluntary system why is not the
18 same thing good for everybody? A direct answer to that
19 is, in my opinion, at least you cannot get the disadvan-
20 tages of the voluntary system if you have a monolithic
21 system in for everyone.

22 Mr. Kilgour used the word "monopoly";
23 I do not want to get fancy, but there is a word that I
24 learned, monocracy - a monolith is where there is one
25 provider of a service, one company and a monocracy is
26 where there is only one purchaser. It seems to me that
27 is the critical difficulty here that as far as the
28 medical profession is concerned on a government monolithic
29 plan, they have only one person to buy their service and
30 that is the government, whether they do it directly or



1 through some other way, ultimately the man that pays
2 the piper calls the tune and as long as the doctors
3 have a competing system as it is now, any time they do
4 not like the way it works they can move to another town
5 or find a new way of practising the same as individuals.

6 If the doctors have no way to turn
7 except the Government, in other words, only one place
8 to apply their services, it seems to me we are destroying
9 the basic thing that has made progress in the medical field
10 on this continent, new doctors coming into medicine.

11 It is important, for the sake of discus-
12 sion, if we immediately brought everybody into this
13 voluntary plan that it would continue to work as well
14 as it has in the past but would it with our children
15 and grandchildren?

16 The present doctors who have grown up
17 under the present system would not change their spots
18 overnight. They have been providing some good service
19 to people, going out and doing a good job.

20 If they had to work for only one
21 employer, would we have the same type of doctor going
22 into the medical profession, would we have the same
23 interest in the welfare of the patients as we have under
24 this system?

25 Let us assume we have a government
26 plan in as it is for those under the present voluntary
27 plan and extend that to everybody in Canada; is it not
28 making it very difficult to advance from that point to
29 the next point - we would need legislation to change the
30 system.



1 In the interplay of the present plan
2 there is constant improvement. One company puts up a
3 plan to do something better for its people and the other
4 company copies it. Where is that incentive coming from
5 if there is only one plan for all Canadians?

6 I have not said much more than Mr.
7 Kilgour but maybe in different words.

8 THE CHAIRMAN: What follows along that
9 same thought is being in opposition too, I would still
10 call it a monopoly in terms of Canada and having in mind
11 that you represent a company that is based in the United
12 States, we appreciate your connection, your long standing
13 and broad service based in Canada but ---

14 COMMISSIONER McCUTCHEON: Dominating
15 influence.

16 THE CHAIRMAN: That is what I am trying
17 to say. Can you visualize a program developing in
18 Canada that would be measurably different from that
19 that would exist in the United States?

20 MR. FITZHUGH: You mean a program by
21 the Metropolitan?

22 THE CHAIRMAN: No, of health insurance,
23 a governmental program of health insurance.

24 MR. FITZHUGH: I certainly can. It has
25 happened, take your hospital insurance in Canada; every
26 province has a hospital plan, there is no such thing in
27 the United States so there is no necessary connection.

28 I would think that basic principles
29 are the same in both countries and some things to the
30 extent of basic principles I would hope they would both



1 follow along the same general approach.

2 Within that, however, there are diffe-
3 rent forces in Canada, it is a different situation in
4 many ways so there is no reason why the same plan should
5 not be in force in the other.

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1 THE CHAIRMAN: That was not my question and
2 I must have put it poorly.

3 MR. FITZHUGH: I am sorry.

4 THE CHAIRMAN: That you understood it that
5 way. What I am trying to bring out, if I can, is
6 whether you could have what would be essentially a
7 compulsory system on one side of the border in medical
8 service and a voluntary system just south of the line?

9 MR. FITZHUGH: I would say yes. I cannot see
10 why you couldn't.

11 MR. KILGOUR: As a Canadian I can express
12 the opinion that too many of our doctors would cross
13 the border if you make such a plan.

14 THE CHAIRMAN: Is there a legitimate fear in
15 that regard?

16 MR. FITZHUGH: Well I think Mr. Kilgour
17 should answer that, he having raised the point. I
18 certainly agree with him and the experience in the
19 English doctors certainly indicate it is a legitimate
20 fear.

21 MR. KILGOUR: I think one can see it anywhere Mr.
22 Chairman. There are in many fields direct competition
23 between Canada and the United States in scientists,
24 in actuaries, in engineers. Anyone who is momentarily
25 unhappy in their present job, if they put themselves
26 in the right place, they can move across the border
27 and certainly in as scarce a calling as the medical
28 profession, I am completely certain -- not to detract
29 from the loyalty of a great many Canadians, medical
30 men but that if conditions here in any sense became



1 intolerable under any monopoly there is always the
2 danger -- people are much happier if they can go
3 across the street, even though they never go but the
4 fact they have the choice of being able to go across
5 the street and stay there, and almost certainly many
6 men say this is where I came in and this is where I
7 go out. I don't hesitate -- certainly happens in
8 business.

9 If you try to keep an unhappy or underpaid
10 group of experts in any field, they do not remain long.
11 Enough of them will move off so that you have got an
12 acute problem.

13 THE CHAIRMAN: On the question of what you
14 get for your money, for your premium -- what the
15 purchaser of the service would get for his premium,
16 it is suggested that a Governmental plan could operate
17 more economically and naturally I am reminded that
18 you have acquisition -- the company will have acquisition
19 costs. Now are there justifications for having
20 acquisition costs in the insurance field where they
21 might be avoided by some other plan? What are any
22 services rendered or performed to earn that commission
23 which might justify or might not, I don't know, but
24 in your present situation to acquire the business you
25 pay a substantial commission do you not?

26 MR. KILGOUR: Acquisition costs?

27 THE CHAIRMAN: Yes.

28 MR. KILGOUR: Yes sir, in one sense we do
29 and this I think has to be put in this light that if
30 it has not been for the fact that there have been



1 sales organizations selling the value of insurance
2 and bringing to people the protection that they need
3 and want, we would not have had in this country
4 perhaps ten per cent of the coverage that exists today.

5 We have seen in the whole history of
6 insurance that without a sales organization, people
7 grope. They put off. They do not buy the thing
8 that is necessary so certainly there has been no
9 question -- the sample of that in life insurance and
10 health insurance on this continent has been tremendously
11 stimulated and developed by the sales organization who
12 go out and sell employers the possibility of putting
13 in plans that will cover their employees; sell
14 employees the coverage that they may need if an
15 employer will not put in a group plan.

16 I think our sales organizations have
17 thoroughly earned the commission that they have been
18 paid over the years.

19 Now conceivably and in fact a compulsory
20 plan, such as for example the Canadian Hospitalization
21 Plan, provincial hospital plan has not acquisition
22 costs to it. You are just told pay your money, pay
23 your tax. The fact is the total hospital costs are
24 very much greater than they were under voluntary plans
25 we had a year ago so one cannot compare merely the
26 acquisition costs under voluntary plans with what the
27 acquisition costs would be under a government plan.

28 MR. FITZHUGH: May I supplement that? I am
29 not disagreeing at all. I am agreeing completely. I
30 would like to supplement it a little. I think when we



1 are talking acquisition costs it is essential to
2 distinguish between group insurance and individual
3 policies.

4 The vast majority of coverage in Canada is
5 through a group policy issued to the employer to
6 cover his employee, the acquisition cost and the total
7 administrative costs under those policies, I submit, is
8 very low. Actually it's something less than -- well
9 under ten per cent is the average total administrative
10 expense on group policies of this nature in Canada.

11 Now when you come to individual policies
12 there it seems to us that there is a clear choice, if
13 you want a voluntary system. For reasons which we
14 have already said, we believe the voluntary system is
15 essential to preserve medical care and if the voluntary
16 system costs a little more, it is worth it to preserve
17 the standard of medical care. Let us assume for the
18 moment the advantages of the voluntary system has
19 individual choice which the experience has indicated
20 that to get coverage, to get the people covered
21 somebody has got to go out and persuade them to buy
22 a policy.

23 As Mr. Kilgour said on life insurance without
24 agents they don't buy it no matter how good a bargain
25 it is. They don't buy it unless somebody goes and
26 sells it to him. On the prepayment policy plan on
27 their individual policies they have a much lower
28 expense rate than the insurance companies have but
29 have practically no coverage because people do not
30 walk in to buy. The insurance companies have a higher



1 expense rate but they have a much broader coverage so
2 it is clear that under the voluntary system do you
3 want a broader coverage and somewhat higher expense
4 or in order to have a lower expense rate are you
5 satisfied with having very few people covered?

6 Now I agree that this is all in the proposition
7 that you agree that the voluntary system is better than
8 the compulsory. If you have a compulsory system, you
9 avoid all those acquisition expenses but in place of
10 them, as Mr. Kilgour said you get, in our opinion,
11 deteriorating quality of increasing actual cost not
12 just plain administrative cost.

13 This expense of the individual policies,
14 I don't think, is as bad as some people have indicated.
15 If I can just take a minute on that. You say what
16 does the agent do to earn his commission? His first
17 commission I have already indicated. If he doesn't
18 go out and persuade a man to buy it, tell him the
19 advantages to it, they don't buy it.

20 As to his renewal commission, our experience
21 has indicated that even if he once bought the policy,
22 when it comes time to renew the policy there are other
23 pressures on him. He might want to buy a television
24 set or something else. He needs to be convinced all
25 over again this is something he should have for his
26 family. If he wants to have the policy explained he
27 calls his agent. If he has a claim the agent helps
28 him fill out the claim papers, etc. What the agent
29 gets for the renewal is relatively small. On the
30 individual policy, in our company, on the first year's



1 commission is paid to the agent twenty-five ~~per-cent~~ of
2 the premium and that is for going out and getting him
3 into the plan. That gradually goes down until after
4 ten years it's five per cent of the premiums and that
5 would average out to obviously something like ten --
6 in that general area, and we think that is well worth
7 it to maintain the voluntary system.

8 Under the compulsory system one might think
9 that is all that costs but it isn't quite that simple.
10 The compulsory system is hiding the cost. The
11 government would still have to collect the money from
12 somewhere and pay the cost of these things. They have
13 to pay the doctors. Pay the claims. That is all
14 buried somewhere in the tax collecting system, wherever
15 it might be.

16 THE CHAIRMAN: You have to pay the doctors
17 and the claims too?

18 MR. FITZHUGH: That would be the same either
19 way.

20 THE CHAIRMAN: I was thinking in terms of
21 that acquisition cost, whether I was following you.
22 You say it is going to cost the government something
23 to collect the premiums. Do you think that would be
24 comparable to your acquisition cost?

25 MR. KILGOUR: No. I would be less than honest
26 if I did not say that the acquisition costs under a
27 voluntary plan is higher than the cost of bringing
28 people into a compulsory plan would be, if you are
29 looking at that one piece of the cost, but that is a
30 relatively small piece of the cost. The big piece of



1 the cost is the benefits themselves and as has been
2 indicated under the voluntary plan, as indicated by Mr.
3 Kilgour, the benefits themselves have risen tremendously.
4 Under a government plan, we believe, and we agree
5 it's impossible to prove this but we believe the total
6 cost of the program would be higher under the compulsory
7 plan than the voluntary plan despite the fact this one
8 question of cost is higher under the voluntary plan.

9 THE CHAIRMAN: I think Mr. Kilgour, if I
10 understood you rightly, you suggested there has been
11 some new developments through the voluntary plan. What
12 did you have in mind there?

13 MR. KILGOUR: There have been many developments
14 in recent years in providing insurance, voluntary
15 insurance, and I think perhaps there have been three
16 or four, half a dozen in the last five or six years
17 that are worth mentioning today. Certainly the group tech-
18 niques and its use has been tremendously broadened
19 in the last few years. There is no question, that one
20 can cover people more adequately with less selection
21 and much less cost through variations of the group technique.
22 We may avoid selection against the company where you
23 can quote your premiums through a common source.

24 The comprehensive form of coverage is proving
25 extraordinarily valuable and it is a relatively new
26 innovation. I think it might be interesting if I
27 could, and I have a form here, give you the experience
28 under one comprehensive plan. For last year, to
29 illustrate the workings of what we think is a first
30 class comprehensive scheme -- this is, as I say, a relatively



1 modern innovation -- comprehensive plan. Here is
2 an outline of one plan. This plan covers all
3 employees and retired personnel and their dependents
4 and it is in our own company under covered expenses
5 or all reasonable charges necessarily incurred through
6 the service of physicians, surgeons, drugs by physicians,
7 prescription services and registered nurses and in
8 fact virtually all health expenses recommended by the
9 attending physician as being medically essential;
10 goes much broader than medical care.

11 The plan provides for \$25.00 a year deductible
12 for each individual with a maximum deductible for a
13 family, regardless of the number of children of \$75.00.
14 There is a co-insurance provision which provides that
15 the plan pays 80 per cent of covered expenses. Twenty
16 per cent is paid by the individual but since the total
17 expenses incurred are eligible as income tax deductions,
18 individuals having large claims in a particular year
19 this constitutes very complete protection. Here is
20 the experience on this plan last year which I think
21 is quite intriguing. Covered 1990 contributors
22 and their dependents. That I believe is a group of
23 some 5,000 people. An examination of the claims in
24 1961 reveals the following facts: out of the total
25 contributors 73 per cent had no claims. In
26 other words, the deductible of \$25.00 per person or
27 \$50.00 per man and his wife and \$75.00 if they had
28 children, covered their total medical, drug, all health
29 care expenses during the calendar year 1961 for 73
30 per cent of this group. Twenty-four per cent -- 477



1 contributed claims of less than \$300.00. Two per cent
2 had claims from \$300.00 to \$600.00. Half of one
3 per cent -- eight people had claims from \$600.00 to
4 \$1,000.00 and half of one per cent had claims with
5 \$1,000.00 and actually they averaged \$2100.00. Now
6 to me this is insurance at its best. Seventy-three
7 per cent of the group did not require anybody to
8 intrude in their relationship with the doctor. Paid
9 their bills the same as they pay their telephone bill;
10 or any other small, minor item.



1 THE CHAIRMAN: That is because of the
2 deductible feature?

3 MR. KILGOUR: Yes, sir. In other
4 words, 73% of them didn't have to fill out a form, do
5 anything, pay a bill, except for their telephone.

6 THE CHAIRMAN: This costs up to \$75?

7 MR. KILGOUR: Yes; and yet at the top
8 we had six people out of this group of 5,000 where the
9 total bills, nursing, drugs, whatever thing was required,
10 ran \$2,100 per family, which would be very shattering,
11 because those were moderately-salaried people. But it
12 is one of the developments in insurance.

13 To quote a phrase, a government plan,
14 covering 100% of the people, is almost redundant,
15 because 73% are able to look after it as easily as
16 looking after their milk bill.

17 THE CHAIRMAN: Do you regard that as a
18 deterrent?

19 MR. KILGOUR: Both as a deterrent and
20 an economy. There is no question that there is a great
21 deal of paper work. If Mrs. Jones goes to see Dr. Smith,
22 he has to write out a form, send it to the insurance
23 company, a cheque is sent out for \$5, you have probably
24 spent two or three dollars getting five dollars.

25 Here, they send it in and that is all,
26 and prescription drugs we pay. The normal family may
27 have two or three prescriptions a year, and they keep
28 the receipts and if they only come to \$10 at the end of
29 the year they forget about it.

30 THE CHAIRMAN: What effect, if any, has



1 this deductible, this built-in deductible feature of
2 the policy, on the amount of premium?

3 MR. KILGOUR: Well, it means in this
4 instance that 100% of the cost of this plan can go to
5 the 27% of the people that run into trouble; there was
6 nothing paid to the 73%. In effect, the total insurance
7 cost of the claims is being directed to the people in
8 trouble and none to the 73% who had no trouble that
9 particular year.

10 They all have the knowledge that they
11 are covered, but, in fact, you are directing all your
12 energies and all your premiums to the groups that have
13 claims in the particular year.

14 THE CHAIRMAN: Would there be any merit
15 in this suggestion, that the insurance that you advocate
16 and support today is much more accessible to the groups
17 than to the individuals and that by and large the indivi-
18 dual is left out of the picture?

19 MR. KILGOUR: There are certain self-
20 employed individuals who do not normally have access to
21 groups, but in the last few years there have been many
22 extensions of groups; we have covered Chambers of
23 Commerce in many cities, there have been bar association,
24 medical association, farmer groups. There has been some
25 extremely interesting experimental work done, and working
26 satisfactorily, on extending the group principle to
27 people that were, a few years ago, considered too diffi-
28 cult to cope with.

29 But, there are now ways to extend it to
30 larger groups, and in another few years there will



1 dramatically become larger numbers.

2 THE CHAIRMAN: I don't know if you
3 were in Winnipeg and heard the submission, I think it
4 was from the Winnipeg Medical?

5 MR. KILGOUR: Yes, I was.

6 THE CHAIRMAN: I am thinking more
7 particularly of submissions we heard in Regina and one
8 of the two voluntary groups which took groups only and
9 membership of which was not open to individuals, and
10 we have heard of other areas, but I think that was the
11 most pronounced group one we heard of.

12 Now, when you have that phase, the
13 insurer restricting its coverage to groups only, is
14 there something really serious there to prevent the
15 extension to individuals?

16 MR. KILGOUR: Happily, there are a good
17 many companies in the individual field. It is a much
18 more difficult field for a company to operate in. We
19 feel we can provide much more valuable service by grouping
20 people than under individual plans.

21 But individual plans are very good, if
22 they can't get any other coverage.

23 MR. FITZHUGH: There are 479,000 people
24 in Canada who have an individual health policy, on an
25 individual basis.

26 THE CHAIRMAN: Is that in the stock or
27 the mutual companies?

28 MR. FITZHUGH: Both stock and mutual.

29 THE CHAIRMAN: This would include the
30 prepayment plans?



1 MR. FITZHUGH: No, it is just in the
2 insurance company plans. The prepayment plans do not
3 have as many individuals covered because they don't
4 have the salesmen to go out and get them.

5 THE CHAIRMAN: You say roughly 480,000?

6 MR. FITZHUGH: Yes.

7 THE CHAIRMAN: How many in the groups?

8 MR. FITZHUGH: The figure I have in
9 front of me, that is 13% of the total. So it would be
10 about $3\frac{1}{2}$ million, because we have about 4,000,000
11 covered altogether, of which $3\frac{1}{2}$ million are under groups.

12 THE CHAIRMAN: You are running about
13 9 to 1?

14 MR. BERRY: 7 to 1.

15 MR. FITZHUGH: A little more than 7 to
16 1. But if you consider the distribution of people in
17 Canada - I don't have these figures, but I would think
18 very likely that people who are eligible for group
19 insurance - it is probably 7 to 1 also, it wouldn't be
20 too far out.

21 THE CHAIRMAN: I think 7 to 1 is
22 correct on my arithmetic.

23 COMMISSIONER VAN WART: Are many of
24 those 480,000 individuals over 65 years of age?

25 MR. FITZHUGH: It is a good substantial
26 number. We can get that figure for you. I wouldn't
27 know where to put my finger on it, but I can assure you
28 we have a good representative number over 65.

29 THE CHAIRMAN: The 480,000, have you
30 any limitation there of coverage, any qualification of



1 coverage by way of medical examination or exclusion,
2 either age or previous disease and that kind of thing?
3 When we start to think of the whole population we have
4 to take in what may be called the medically uninsurable
5 which an overall plan would seek to accomplish.

6 MR. FITZHUGH: Individual policies -
7 generally a man must have some evidence of insurability.
8 He does have to fill out a form of statement of health.

9 THE CHAIRMAN: If he misrepresents it
10 he may find himself out of luck afterwards?

11 MR. FITZHUGH: Yes, because he will get
12 what he shouldn't get if he misrepresents. But if he
13 tells the truth and gets the policy, at least in our
14 company - and I am sure it is the same in other companies -
15 once he has got the policy we have never cancelled or
16 changed the policy because of deterioration in health.

17 I would say it is the general practice
18 of most of the life insurance companies, and I just
19 can't speak for the other companies. /Putting it another
20 way, this has been an evolving practice, and the life
21 insurance companies I think were the first ones to adopt
22 the philosophy - individual policies started in casualty
23 tradition, contracts out for a ship or a house; at the
24 end of a period of years if you don't like the look of
25 a ship you don't issue a policy, and that was the practice
26 for many years.

27 Certainly there are many companies, and
28 Mr. Fitzhugh's and ours are two, that clearly do not
29 cancel or not renew policies for deterioration of risk.

30 We have taken the attitude that we must



1 enter into a long-term contract with this man regardless
2 of what his health will be afterwards.

3 THE CHAIRMAN: The only condition is
4 continuing payment of the premium?

5 MR. KILGOUR: Yes, or to avoid anything
6 that might look like fraud. When you stop and think -
7 I mention this figure because it is in my head - in rural
8 Manitoba only 30% of the population have medical coverage.
9 It is a strange coincidence, but the man who wants it is
10 usually the man who has something wrong with him, who
11 applies for an individual policy.

12 If you have a poor risk you end up
13 with a lot of claims and you wonder why you are in
14 business.

15 THE CHAIRMAN: If we want to talk
16 about total coverage, can you only insure the good risk?

17 MR. KILGOUR: No, sir. That is one of
18 the things that I think is frequently misunderstood.
19 If you can get an absence of selection ---

20 THE CHAIRMAN: What do you mean by
21 "absence of selection"?

22 MR. KILGOUR: So that only the ill
23 people go into buy. A good example of that was that
24 under individual policies, when we first went into the
25 business, we got fairly well buzzed to death by you
26 couples who frequently bought maternity benefits; you
27 are going to get your premiums back during the period
28 you are having your children and then you can drop it.

29 If you are getting a cross-section of
30 people that maternity benefit is easy to put in. We



1 could, for example, insure all the farmers in Manitoba,
2 if they want it.

3 THE CHAIRMAN: If you pardon a personal
4 reference, and it is only to illustrate it, I carried
5 a sickness and accident policy in one of the fairly
6 well-known companies, it was not a fly-by-night or
7 anything of the kind, and I think I carried the policy
8 for 30 years, at a reasonably substantial premium.

9 But there came a day not so long ago
10 and they said I had passed a certain age and they said
11 they would only continue me for accident only.

12 MR. KILGOUR: Well, there would be two things
13 One would be the level of premium at which that policy
14 was written. There is no doubt that many policies,
15 when they were written, contemplated coverage only up
16 to 65.

17 THE CHAIRMAN: They said: "No, you have
18 been on the books for 30 years now without a claim and
19 you are home free".

20 MR. FITZHUGH: You reminded me - I
21 would like to correct a statement made a few minutes
22 ago that we have never discontinued a policy solely for
23 deterioration of health. That is a correct statement,
24 but I should have said that some of the older policies
25 had an effective age limit.

26 Your point is that the company takes the
27 good risk and the poor fellow who can't afford it is out
28 of luck. As Mr. Kilgour said, no one company could go
29 out and offer to take anybody, the lame, the halt and
30 the blind.



1 THE CHAIRMAN: I put the question to you, why
2 not?

3 MR. FITZHUGH: No one company could go out
4 and offer to take the lame, the halt and the blind
5 if the other competing companies in the field didn't
6 do so, because they would get a large percentage of
7 the lame, the halt, and the blind. There is no place
8 for them to get the extra money to pay the extra
9 claims of those people, except from their healthy
10 policy holders, so their premiums for the healthy policy
11 holders would be raised above the level of the companies
12 that didn't take the risk, so that the healthy policy
13 holders wouldn't come to that company.

14 If I may go back to the statement of the
15 Canadian Health Insurance Association at the preliminary
16 hearings of this Commission.

17 The Canadian health Insurance Association
18 is currently developing a specific program
19 to achieve these ends, for presentation
20 at a later Hearing of this Commission.
21 Our proposed plan maintains the
22 advantages of competition which are most
23 essential for the successful operation,
24 financial or otherwise, of any plan of
25 medical care.

26 No one company can do it, but the group of
27 companies in prepaid people as a whole, can bring it
28 in on a voluntary basis, provided it is done by
29 everybody.

30 I am sorry I don't think it would be proper
for me to go into it too much further, because that
is not our job, but we recognize that weakness of the
present business, and the insurance business has a
proposal to make to you at the Toronto hearings, so that



1 that objection will no longer hold true.

2 THE CHAIRMAN: In addition to possible
3 discontinuance of coverage due from time to time to
4 exclusions or riders being attached to policies, and
5 a lot of the so-called fine print in insurance policies
6 and contracts, what is the situation regarding the
7 content of the contracts. I mean to say, this
8 matter of the fine print and that kind of thing?

9 MR. FITZHUGH: There are two questions there,
10 one the riders and exclusions. That is in effect
11 the same kind of question as to why we don't take
12 somebody in the first place. Granted that under the
13 present situation we don't think we can take these
14 poor risks, because it would be priced out of the
15 market. A number of companies, including our own,
16 have said, can't we take them on some basis? If a
17 man has had one particular kind of a history he
18 still could get protection for accidents or any other
19 illness, except this bad history, so we have thought
20 it was better to give him protection for everything
21 else, rather than deny him protection altogether, so
22 that is where the riders come in.

23 THE CHAIRMAN: That is originally?

24 MR. FITZHUGH: At the original time. We
25 never add a rider later.

26 The fine print, that is also ancient history.
27 I don't know about in Canada, but in the United States
28 it is illegal to print a policy with no more than
29 ten point type. Maybe the fine print argument was
30 valid some time ago, but the companies now value their



1 reputation too much I think to do what was alleged
2 was done some years back, I would say it was before
3 my time, of issuing a policy to everybody and
4 underwriting. At the time of the claim they say
5 we should not have taken you, and point to some fine
6 print in the policy. That is not being done now.

7 COMMISSIONER BALTZAN: The size of the
8 print would have to be enlarged a little bit in
9 accordance with the age of the individual.

10 THE CHAIRMAN: Has the principal of the
11 statutory policy such as we know in fire insurance
12 been adopted in connection with sickness and accident
13 insurance?

14 MR. FITZHUGH: Yes sir, we have statutory
15 provisions that are under provincial supervision, and
16 the provincial superintendents of insurance meet, I
17 think, not less frequently than annually, at which
18 they discuss whether or not there should be any changes
19 in the reforms. I think there may well be some
20 severity of practice in Canada.

21 THE CHAIRMAN: No, but I was wondering if it
22 applied, because for the number of years that I
23 attended the insurance conference from time to time I
24 didn't know that it applied to sickness and accident.
25 This may be a development since I was there.

26 MR. FITZHUGH: And to the extent that there
27 is, we have spoken of our practices with considerable
28 pride, to the extent that there is anyone invoking a
29 harsher practice, it is up to the superintendent, if
30 they feel that they have not got strong enough provisions



1 in there, I suppose, to put more severe ones in.

2 THE CHAIRMAN: Does the same thing apply?
3 That the policy must conform, if there was something
4 in the policy that the conditions do not permit, that
5 that does not apply. It might just as well not be
6 in the contract. Does the same idea prevail as in the
7 fire insurance, that it must be in red ink?

8 MR. BERRY: No sir, there is no provision
9 that part of the contract must be in red ink.

10 THE CHAIRMAN: No, merely if there is a
11 variation from the statutory condition, that the notice
12 of that variation must be prominently stated?

13 MR. FITZHUGH: There are no variations
14 allowed. The statutory conditions are spelled right
15 out in the Act.

16 MR. BERRY: And they are in the policy.

17 MR. HALL: Mr. Chairman, I have some questions,
18 but they are mostly a request for statistical data
19 which Mr. Kilgour and Mr. Fitzhugh have undertaken to
20 provide when I give them the details. I had two or
21 three other questions which have been mostly covered
22 now.

23 COMMISSIONER FIRESTONE: Mr. Chairman, I
24 would like to congratulate Mr. Kilgour and Mr. Fitzhugh
25 on their readiness to give us their best advice on
26 what is an important national social and economic
27 problem in Canada. Your appearance here is evidence
28 of business leadership at its best, and we are
29 grateful to you. If I may, gentlemen, addresss the
30 questions to Mr. Kilgour, but it is understood that



1 he or anyone else can deal with the question.

2 I will commence following the outline of
3 your submission, and then deal with some matters that
4 are not covered in your submission.

5 I would like to turn first to page 2,
6 paragraph 3, and I quote:

7 "It may be trite to say so,
8 but the basic characteristic of
9 the coverage which we provide is
10 that it is voluntary."

11 I wonder, Mr. Kilgour, whether we could have a little
12 discussion about this voluntary contract. You indicated
13 to us that the bulk of your insurance in the health
14 field is group insurance, something like $3\frac{1}{2}$ million
15 people against close to 500,000 for individual
16 insurance. Now, if a large company negotiates with
17 you a group insurance contract, what form does this
18 contract take? How is such a contract arrived at,
19 and how do the members of this company participate?

20 MR. KILGOUR: To answer briefly, sir, it
21 would be that one or more companies, or vehicles,
22 who sell plans, sit down presumably with the
23 employer, or some representative of an employer, and
24 make proposals as to what they suggest will be the
25 best plan for that company, and its cost and benefits.
26 There may be union negotiations, and in due course,
27 by their own processes they determine the plan and
28 contribution rates, and how much the company will
29 pay, and after considerable competition, in due
30 course a decision is taken and a plan installed in that



1 firm.

2 COMMISSIONER FIRESTONE: Well then, we will
3 have one company having a group plan with one
4 insurance company, and I take it all the employees
5 of this company will be covered, is that the way it
6 is?

7 MR. KILGOUR: Yes sir.

8 COMMISSIONER McCUTCHEON: Not necessarily
9 though.

10 MR. KILGOUR: No, there is frequently a
11 right not to go in for existing employees.

12 COMMISSIONER FIRESTONE: Are there group
13 contracts where the company assists by requiring that
14 all employees become covered. Are such policies in
15 existence?

16 MR. KILGOUR: My understanding, Mr. Berry
17 can check me if I am wrong, so far as our company is
18 concerned we require a minimum number to put the plan
19 into effect, frequently 65 to 70 per cent, but most
20 employers do not choose to compel their employees to
21 go in, and if it is a good plan, and with proper
22 enrollment methods you will get that 65 per cent or
23 70 per cent. Then new employees will have to join.

24 COMMISSIONER FIRESTONE: We have the plan
25 whereby say 75 to 80 per cent have joined the plan
26 on a more or less voluntary basis. Somebody else is
27 being employed by the company, and he is asked to
28 join the plan. What happens if this particular person
29 says I don't want to join the plan?

30 MR. KILGOUR: That may be the rules of the



1 game, and he joins.

2 COMMISSIONER FIRESTONE: And you would call
3 that voluntary?

4 MR. KILGOUR: Well, in theory he has quite
5 a large number of employers to choose from. That is
6 one of the employment practices, just as is the lunch
7 hour and working period.

8 THE CHAIRMAN: He would join the union.

9 COMMISSIONER FIRESTONE: Just to continue
10 a little on this voluntary feature in group plans.
11 Presumably most companies offer 50 per cent, or
12 some similar proportion of the cost of the premium
13 with the employee paying the other 50 per cent, is
14 that approximately correct?

15 MR. KILGOUR: It varies widely from employers
16 in some instances they negotiate plans where the
17 employer pays all. In some instances the employers
18 pay hardly anything, and all the shades in between.

19 COMMISSIONER FIRESTONE: Would you say the
20 majority of plans with which you are familiar cover 50
21 per cent or better employer contribution?

22 MR. KILGOUR: I would say that is the right
23 range sir, without being --

24 COMMISSIONER FIRESTONE: We don't want to be
25 dogmatic.

26 MR. KILGOUR: Thirty to sixty, or somewhere
27 in there.

28 COMMISSIONER FIRESTONE: It would mean that
29 in the initial instance, as the company tries to
30 get the plan established and get this 80 per cent



1 that you are after, that the company says to its
2 employees we are going to pay, let us say 50 per cent
3 and you pay 50 per cent. Now, of course if you don't
4 join you won't get the contribution which we are
5 making, and you will have to look after your own
6 interests. Is that not the position?

7 MR. KILGOUR: This is somebody who chooses
8 not to go in at the beginning.

9 COMMISSIONER FIRESTONE: The initial phase,
10 when the employer has to get the 80 per cent, and he
11 says to his employees I will pay 50 per cent, and
12 you pay 50. Please sign on the dotted line. Would
13 you not say that those people who would not sign
14 on the dotted line would be losing the 50 per cent
15 contribution of the employer?

16 MR. KILGOUR: Yes sir.

17 COMMISSIONER FIRESTONE: Would you not also
18 say that perhaps this is a penalty that the employee
19 who is not joining is facing, because he does not
20 volunteer to join?

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H/dpw 1 MR. KILGOUR: Well, perhaps again I
2 can only offer an opinion because when you are talking
3 about a hypothetical person I would think the reason he
4 does not want to go into the plan is some highly
5 personal reason; he may not plan to stay with the
6 employer long, he has a policy of his own, there may be
7 a brother who is a doctor who looks after him for nothing.

8 There may be a combination of things
9 that he chooses not to go in and he has concluded it
10 is to his advantage to stay out so he stays out. He
11 evidently thinks it is profit to stay out, it is a case
12 of just judging the element.

13 COMMISSIONER FIRESTONE: I am asking
14 these questions because when we talk of voluntary in
15 group plans it seems to me there are certain compulsory
16 features in terms of getting 50-cent contribution or in
17 terms of the employer saying "I cannot give you a job"
18 and it seems to me when people look for jobs that this
19 is a fairly compelling reason, maybe not in your eyes.
20 This may be a matter of judgment.

21 MR. KILGOUR: I would make one distinc-
22 tion that if you say compulsory in any sense parallel to
23 a government compulsory plan there are some very impor-
24 tant distinctions; one is that both the employers and
25 employees at the end of three months or six months, if
26 they are unhappy about it, they can turf it out the
27 window or buy another plan or amend the plan or make
28 any number of changes in it every year.

29 There may be an element, a greater
30 number of this community and following the plan that way



1 if they think the plan is not the right one it can be
2 changed at the end of every year and this has not been
3 our experience with governments.

4 COMMISSIONER FIRESTONE: I am happy to
5 have your comments and your views on the government
6 scheme. We were just discussing the compulsory as used
7 in your sentence on page 2.

8 MR. FITZHUGH: May I supplement that?

9 COMMISSIONER FIRESTONE: By all means.

10 MR. FITZHUGH: Our experience, I think,
11 is a little different from Mr. Kilgour's on this condi-
12 tional employment. I would say most of our group
13 policies, it is not a condition of policy even for new
14 people, they can take it or leave it. I suggest it is
15 a matter of semantics but I dislike the word that it is
16 a penalty if they do not take it, it is an advantage if
17 they do take it and they know it. That is not a charac-
18 teristic of the group insurance.

19 One of the largest policies in either
20 the United States or Canada, the General Electric policy,
21 the Canadian General Electric policy here, when that plan
22 was put in the employer gave his employees a choice "Do
23 you want Plan A or Plan B?" Plan A was the standard,
24 at that time, basic plan that paid hospital benefits
25 and surgical benefits and that sort of thing and then
26 there was Plan B which was a better coverage and
27 co-insurance and they were asked which they wanted at
28 that time, Plan A, the standard plan or the brand new
29 concept of a comprehensive plan.

30 They were given your choice and it so



1 happens about 90% took the comprehensive plan. That is
2 another story but the point is that they were given a
3 choice.

4 Take the United States Civil Service
5 Plan for their employees, those are examples to show
6 they can have a choice, they have three or four, maybe
7 more, maybe six or seven different plans which their
8 employees can select and still get the government contri-
9 bution to the program.

10 The New York State employees have a
11 choice between a regular Blue Shield Plan and the closed
12 panel plan. In New York City the employees do not have
13 a choice, they just have the one and only 50% of their
14 employees are in it. It runs the gamut.

15 That is the point I think we are making
16 on the voluntary system, that it can be done either way -
17 they can have a choice or no choice or anybody that does
18 not like it they can change it. That is why we think it
19 is voluntary.

20 COMMISSIONER FIRESTONE: Thank you very
21 much. We were discussing generally the difference
22 between persons covered under a group policy and under
23 individual policies; would it be possible for you to give
24 us an indication of premiums for a standard type of
25 policy covering exactly the same kind of thing, group
26 as against individual? I am not after a scientific
27 measurement as an exact figure to the last cent or ten
28 cents or dollar but I am more concerned to get a rough
29 idea of the relative position between an individual
30 person insured under a similar scheme in a group policy.



1 MR. KILGOUR: I would defer to Mr.
2 Fitzhugh.

3 MR. FITZHUGH: We have our actuary
4 here which is a good buck-passing machine.

5 COMMISSIONER FIRESTONE: Please feel
6 free to call on him if you wish.

7 MR. FITZHUGH: I will give a general
8 answer and if Mr. White has some figures or a statement
9 or wishes to supplement it then he can.

10 This is pretty broad talk. You are
11 aware, I know, that group insurance is on a rating
12 basis or the premium rate and exactly the same benefits
13 in group insurance can vary widely so it is difficult
14 to say what the difference between the group and indivi-
15 dual is.

16 I am just raising general principles
17 now. Accepting the fact that the rate in individual
18 policies is within the order of 20% to 25% higher than
19 on a group policy and then that there is little
20 difference, assuming you are taking the same benefits,
21 I would anticipate the net cost on the group and the
22 individual would vary about 25%.

23 The premiums can be quite different
24 because the group premiums are set higher in order to
25 have the group return.

26 COMMISSIONER FIRESTONE: Would you not
27 have to add a higher cost of acquisition?

28 MR. FITZHUGH: That is the 25% I am
29 talking about.

30 COMMISSIONER FIRESTONE: That is



1 covered by the 25%?

2 MR. FITZHUGH: Yes.

3 THE CHAIRMAN: It is not 25% forever,
4 it is a declining percent?

5 MR. FITZHUGH: Entirely aside from the
6 cost of acquisition, individuals cost more than a group
7 because you have to collect a bulk premium, it costs
8 more to collect that individual premium from one million
9 people than to get one cheque from an employer for a
10 couple of hundred thousand people.

11 COMMISSIONER FIRESTONE: In other
12 words, it is in the interest of the individual that he
13 find the ways and means to be covered on a group policy
14 rather than an individual policy?

15 MR. FITZHUGH: If he likes the benefits
16 of the group plan he is going into, if he does not then
17 he can stay out.

18 COMMISSIONER FIRESTONE: Well, how far
19 do you go in measuring groups? What is your definition
20 of a group?

21 MR. FITZHUGH: It is different with
22 every insurance company in Canada, I am sure.

23 COMMISSIONER FIRESTONE: Well, we have
24 the two largest insurance companies in Canada here.

25 MR. KILGOUR: There have been a good
26 many committees on this and at times some of us have
27 been shot down in flames for some of our experiments.

28 Basically the definition of a group is,
29 you have to have some body with whom you can have a
30 master contract or there has to be some recognized



1 entity with whom you enter into a contract and would also
2 have to have some type of collecting treatment that you
3 can classify the people who are members of the group.

4 I think one job we have done a lot of
5 that has perhaps carried group insurance about as far
6 as it can go is with Chambers of Commerce. We will go
7 into a small town or a medium-sized city where there are
8 relatively few large employers and with the co-operation
9 of the Chamber of Commerce the individual employers will
10 agree to pay half the premiums and we will enlist, in
11 effect, all the employees in the town and employers who
12 are members of the Chamber of Commerce.

13 Using that device we have taken group
14 techniques down as low as one man running a grocery
15 store alone or if he has two helpers they can come in
16 too. That is carrying the group definition as far as
17 it can go.

18 As an effective instrument this will
19 demonstrate it will work. We have had very satisfactory
20 experiences and have brought good group plans to employers
21 in small towns. This same technique could cover almost
22 the entire country if people want to go in.

23 COMMISSIONER FIRESTONE: Let us take
24 a complete sample; if an electrical contractor in the
25 City of Winnipeg - say he has three or four employees,
26 there are five in the group; would you cover?

27 MR. KILGOUR: We would go to five.

28 COMMISSIONER FIRESTONE: You would
29 cover this particular company?

30 MR. KILGOUR: Yes.



1 COMMISSIONER FIRESTONE: He does not
2 have to go to the Chamber of Commerce or anyone else?
3 You will cover him?

4 MR. KILGOUR: Yes.

5 MR. FITZHUGH: We will go to three,
6 the competitive enterprise system works but we call it
7 a different name.

8 COMMISSIONER FIRESTONE: Could you give
9 us the name?

10 MR. FITZHUGH: Employee benefit plans
11 and if it is administered much along the group insurance
12 line it has the same effect, three employees can come in.

13 COMMISSIONER FIRESTONE: In the case of
14 this electrical contractor if he has only two people
15 working for him, three including himself, would you call
16 him an employee even if he is the boss?

17 MR. FITZHUGH: That makes three.

18 COMMISSIONER FIRESTONE: He would come
19 under the group?

20 MR. FITZHUGH: Yes.

21 COMMISSIONER FIRESTONE: Now, we have
22 talked about premium and the group covered. Can we now
23 find out what the payments are that you make under these
24 two different types of policies?

25 Now, Mr. Kilgour and Mr. Fitzhugh, in
26 asking you this question, if the information that I am
27 asking you is confidential and you do not wish to release
28 it for business reasons then please say so and we will
29 understand.

30 I understand some of the information, as



1 far as Metropolitan Life Insurance is concerned, is
2 public. Please feel free to put forward any comments
3 that you wish.

4 My question is: what has been your
5 experience in paying out for medical care benefits
6 under your policies (a) under group policies and (b)
7 under individual policies. I am talking of how many
8 cents of the dollar, 80% of the dollar received in
9 premium, 90%, 50%, something of that approximate order
10 would be completely satisfactory for the purpose. This
11 is not a statistical enquiry because we have research
12 people who will be consulting you but we want to get an
13 approximate idea of the state of affairs.

14 MR. KILGOUR: If I can undertake to
15 speak to that first, sir. I would like to make first a
16 marked distinction between the individual policies and
17 group policies and remind you again, if I may, of the
18 difference in character. We have very many of our indi-
19 vidual policies in which there is a high element of
20 risk and a relatively low premium.

21 For instance, one form of individual
22 health insurance policy that we issue a lot of is a
23 monthly indemnity with perhaps quite an important period,
24 30 days or 60 days or even 90 days.

25 These are particularly valuable, they
26 may be payable till age 65 but these are particularly
27 valuable forms of coverage for doctors or other self-
28 employed people who would be financially ruined if they
29 were taken out of play altogether.

30 They do not care about the first month



1 or two, they want to buy a lot of coverage for the
2 disaster.

3 Now, one has relatively few claims,
4 this is in the early years of underwriting, but actually
5 if you are not cancelling for deterioration of a risk,
6 if we are continuing the policies once undertaken will
7 really only be written in the long term and as most of
8 us are relatively recently in the field in that mode of
9 coverage, if one did not have some fairly favourable
10 experience in the early years while some of these people
11 are aging and getting closer to their coronaries, which
12 they worry about, and so on, they would be in very bad
13 shape when any heavy incidence of claims fell in.



1 So that all our individual policies over
2 the last several years our claim ratio averages into
3 the forties. That in the one sense can be said
4 to be -- somebody can say that it is poor. On the
5 contrary, we think that relating it to the very large
6 risks that are at stake, it would only need very
7 few important fluctuations to change that figure
8 radically.

9 The other, as has already been mentioned,
10 is considerably higher expense ratio on policies with
11 only \$40.00 or \$50.00 annual premiums where you
12 have got the fixed costs not like the fire insurance
13 business where you are custom tailoring the policy
14 to the individual and making each one exactly suit his
15 circumstances but where your expenses are higher than
16 on the group form of coverage. So in the individual
17 field our experience is running forty per cent and on the
18 group field we have been running from about 85 to 86
19 or seven per cent. In fact, I have in front of me
20 data for I think it is 21 companies for the year 1960
21 and their group losses were 84.1 per cent of premium
22 income. Their individual losses was 46 giving a
23 weighted average of 76 per cent but because of the
24 difference in the mix of one's business -- if you have
25 very large group costs, we have some in which we pay
26 out over 90 per cent of the premium, 92 or 93, including
27 a two per cent premium tax. We have others on which
28 they are quite small and the costs are appreciably
29 higher so the mix of any business may have an important
30 effect on its cost ratio and on the actual amount that



1 goes out in claims.

2 If I may make one other observation and
3 then Mr. Fitzhugh you may add something. I think it
4 is desirable to remember that in this field claims
5 are only one measure. Certainly we all know that in
6 every other field of distribution the cost of service
7 -- if one goes back to what does the raw material
8 cost -- the wheat that is in a loaf of bread in comparison
9 to what you pay for the sandwich, the spread is
10 considerable. It's in the process of bringing to
11 people the thing they want in a form they want it,
12 when they want it is a costly operation and the
13 Canadian public I think shows in many spheres, the
14 things they buy in stores, the things they put in
15 their homes what they want and sometimes this custom
16 packaging or putting things in the most convenient
17 form, having it exactly suit the individual clearly
18 raises the cost above the raw materials which went
19 into it which are in effect the claims.

20 MR. FITZHUGH: I would say that our figures,
21 in substance, are the same as Mr. Kilgour's. As you
22 say, we are not getting into a competitive discussion
23 here on who is operating more efficiently. Our
24 product mix, or I would venture to say that any
25 difference in his figures and ours is due to the
26 product mix not to one of us being more efficient
27 than the other. The Metropolitan expense rate for
28 group insurance, for our group business put
29 together was 5.61 per cent and our expense rate on
30 individual policies was 45.1 per cent. I am giving



1 these backwards. I am giving you the expense rates.
2 The balance is what goes out; on that 45 per cent --
3 I would like to add one thing to what Mr. Kilgour
4 said that because the voluntary, private personal
5 insurance business has grown so rapidly in the last
6 few years, the amount of product mix, the weight of the
7 brand new business in our total personal business is
8 very high. If we had been issued the same volume of
9 business in twenty years we would be down near the
10 renewal rate of the business. That is pretty close
11 to the cost of -- very heavily weighted by the cost
12 of putting the policy on the books, not only the
13 acquisition but writing the policy, underwriting, and
14 all the rest of it so that our going rate and I am
15 sure Mr. Kilgour's going rate once you get the
16 policies on the books and all those expenses over
17 with is very much less than the 45 per cent.

18 COMMISSIONER FIRESTONE: Thank you gentlemen.
19 If I understand you correctly in the case of group
20 insurance and the insured getting back 85 to 87 per
21 cent in terms of payments for medical care benefits
22 and in the other case 94 per cent, he gets a good
23 deal. He gets as close to a maximum amount allowing
24 for conducting a business.

25 The individual insured person, according to
26 this information, at least on the surface, does not
27 appear to be getting as good a deal because he may
28 get in the case of Great West 40 to 45 cents out of
29 the dollar in terms of medical care service and in
30 the case of Metropolitan Life was 55 cents out of the



1 dollar.

2 Now does the public understand that the
3 reason, one of the reasons for the difference being
4 so substantial between the returns on the two policies
5 is one: the higher cost of ~~writing~~ it and secondly: the
6 necessity on the part of the insurance companies to
7 make an allowance for future contingencies which are
8 much greater in the case of individual policies than
9 is the case in group policies. Now is this point
10 understood by the public because we have encountered
11 a lot of criticism, saying companies, all they put
12 out is forty or fifty cents on the dollar.

13 MR. KILGOUR: Of course, that is taking
14 a minority of the business and again I remind you
15 in our company our individual business is ten per
16 cent of our group business. The minority of business.
17 The majority is not written on medical reimbursement.
18 The majority of our individual health business is
19 written on an income coverage itself and usually
20 people are not trying to cover the first dollar.
21 They are trying to buy very important large benefits,
22 long term, two, five, ten year, twenty year
23 disability benefits and on this you have the annual
24 cost of getting contracts, also collecting premiums
25 whether any claims or not and the inevitable selling
26 expense and the first expense and the maintenance
27 costs. There are really two different products in
28 one. That carries it to extreme but to illustrate
29 the point take the aircraft coverage where you put
30 in a quarter in a slot machine and get \$7500.00 or



1 \$6750, whatever it is for a trip. No doubt the
2 cost of that business is extremely high. The
3 passenger regards it as a valuable service. We are
4 not in that business so I can speak of it only as
5 an illustration. Every now and again if you have
6 to pay out 6 $\frac{1}{4}$ million like they did a couple of weeks
7 ago in New York --

8 COMMISSIONER McCUTCHEON: As a rule the
9 passenger is very happy if he does not collect.

10 MR. KILGOUR: As a rule all our policy
11 holders are very happy if they do not collect too.

12 MR. FITZHUGH: That is an interesting point.
13 On health insurance it is not always the case.
14 Somehow or other people have a feeling when they pay
15 for health insurance, if they do not collect, they
16 claim they have not got a good deal.

17 COMMISSIONER McCUTCHEON: Burn their house
18 down but feel they should get their money out of the
19 policy.

20 MR. FITZHUGH: Out of the health policy, yes.
21 If I may supplement Mr. Kilgour's statements on
22 this individual policy -- I would just like to
23 emphasize again with the expense rate on the individual
24 policy as a going concern, what we should be looking
25 at is the future. Not what has happened in the past,
26 but as a going concern from now on under these new
27 ideas that we are constantly getting is going to get
28 down in the 25 per cent rather than the 45 per cent.
29 I don't think there is any doubt about that and then
30 it is still a question whether that is worthwhile.



1 A composite of the group and the personal, because
2 of the preponderance of the group in our company, the
3 average expense rate exclusive of tax is 12.6 per
4 cent of our entire business.

5 COMMISSIONER FIRESTONE: I think you made
6 a very good point gentlemen that on the group policies
7 the insured get a very good deal and that the
8 individual policy holders are a minority ratio, in
9 one case was seven to one; in your case even ten to
10 one but the fact remains there are many hundreds of
11 thousands of Canadians who are not covered and in
12 order to get coverage for them may require individual
13 policies rather than group policies.

14 Now unless you can come forward with a
15 system for farmers whereby farmers could enter
16 group policies - now you have indicated perhaps there
17 is such a system --

18 MR. KILGOUR: Can get one tomorrow if they
19 wanted it.

20 COMMISSIONER FIRESTONE: Would you indicate
21 to us how you would change -- in other words you
22 would be able to say look you are not getting a good
23 deal under those individual policies --

24 MR. FITZHUGH: We are not saying that. You
25 are saying that.

26 COMMISSIONER FIRESTONE: Quite right. You
27 may not say this yourself but critics may say that.
28 Also if you really want coverage at much better terms,
29 you can get it under the group insurance. How could
30 they work it?



1 MR. KILGOUR: We have a very good illustration
2 -- it has not happened yet, but it is typical, for
3 example, we have a group contract with a number of
4 the grain elevator companies under which they are
5 covering all their members. If you take the Manitoba
6 pool, they have got 75,000 farmers who are members
7 of the pool and deliver their wheat there and they
8 have benefits for all farmer members of their
9 organization and their dependents and that plan is in
10 effect and they are pleased with it.

11 COMMISSIONER FIRESTONE: Who collects the
12 premiums?

13 MR. KILGOUR: The pool. They are handling
14 \$5,000.00 of each farmer each year when he delivers
15 his grain to them and they can deduct premiums and
16 they are very small, three or \$4.00 a year for this
17 accident plan and it is proving a very worthwhile
18 plan. They can just as easily -- I only used that
19 as an illustration. Perhaps I should not have used
20 a name particularly but they can just as easily have
21 their members covered by complete health insurance
22 for all the farmer members and their employees if
23 their members want it.

24 I was intrigued to notice that the rural
25 wives in Manitoba said that they would love to have
26 health insurance. I am wondering if their husbands
27 would take advantage of it. If they would, we have
28 a plan. If they want it, they can get it tomorrow.
29 Every farmer in Western Canada is dealing with an
30 elevator company. The collection device is easy



1 but whether or not as many as 50 per cent of their
2 members would want the cost of a health plan and the
3 premiums taken out of their year's earnings is
4 something that somebody would have to know farmers
5 better than I do to know whether they say aye, yes or
6 no. If they want it we could give them a completely
7 comparable coverage to their industrial bretherns in
8 the cities and if they don't like it they could change
9 it a year from now and get another one.

10 COMMISSIONER FIRESTONE: Can we now turn
11 to the question of the payments that you make for
12 medical care service under your insurance contract.
13 As I understood you to say you would be paying under
14 a number of contracts say 80 per cent of medical
15 care expenses with a 20 per cent co-insurance
16 arrangement. I presume that is one type of contract?

17 MR. KILGOUR: That is one plan.

18 COMMISSIONER FIRESTONE: Have you got
19 another plan where you pay 100 per cent without the
20 co-insurance?

21 MR. KILGOUR: We have one or two plans which
22 we have written on a so-called service basis which
23 is strictly comparable to the service plan but they
24 are rather unusual.

25 COMMISSIONER FIRESTONE: The majority of your
26 plans are based on the co-insurance principle?

27 MR. KILGOUR: No. The majority of our
28 plans numerically in our company, are written on what
29 we call schedule benefits and that normally embraces
30 surgical schedule frequently. For example, if



1 it is in Ontario we try to use the Ontario Medical
2 Association schedule of surgical fees. We have so
3 much per call. Frequently after the first call or
4 second call depending again on what they want in the
5 plan, house attendance, so much for physician in the
6 hospital -- it's custom built for the community, for
7 the employer, what he will pay and what the employees
8 want to pay. In effect, you end up with a program
9 of benefits designed to meet the needs of that group.

10 Therefore, one cannot say whether that is
11 paying 100 per cent, 90 per cent, or 80 per cent
12 unless one knows the precise charge of the doctor in
13 each individual instance because there can be
14 variations. Now we all have some plans that we are
15 not particularly proud of in which an employer or
16 employee said we only want \$100.00 schedule provision
17 in it, the same way they used to have I think \$50.00
18 schedule and they said that is all we will pay. We
19 want a plan for \$3.00 a month or \$2.00 a month.
20 That being the case, they have only partial insurance but
21 that is much better than no insurance. however I
22 do not think one could say -- certainly I couldn't
23 make any more than the broadest guess as to the
24 precise per cent or even the approximate per cent
25 that group plan is paying or through the whole mix
26 of our business. On comprehensive plan we do pay
27 80 per cent. On scheduled, indemnity plans depends
28 on the community; what the doctor chooses to charge
29 in relation to the schedule and the adequacy of the
30 plan they get.

COMMISSIONER FIRESTONE: On this comprehensive



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1 plan you pay 80 per cent of the amount billed by the
2 physician or 80 per cent of the schedule which you
3 specified?

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1 MR. KILGOUR: On a comprehensive plan,
2 we have a definition, reasonable and proper, I would
3 think. In other words, every now and again we have a
4 few problems on the size of the charge. We have a
5 definition; I think it is called "reasonable and proper".

6 MR. FITZHUGH: "Reasonable and necessary".

7 MR. KILGOUR: And we have had a few
8 instances - we all do - where the fee might be something
9 astronomical, and in that case we do such negotiation as
10 we can, and the nurses and physicians have a sort of
11 committee that we can refer anything that is too unhappy
12 to.

13 MR. FITZHUGH: I think if I understand
14 your question correctly, you may be talking a little bit
15 at cross purposes. You tell me if I am right. I don't
16 think it is both. If you have a schedule you don't
17 print a schedule which says \$150 for appendectomy, we
18 don't have a limit in the schedule, and then it says we
19 pay 80% of the doctor charges. You don't have both;
20 you don't have a limit on the schedule and only 80% of
21 that.

22 COMMISSIONER FIRESTONE: I am concerned
23 with the 80%. There may be some medical bills which
24 your company may think are on the high side, and in such
25 cases you say you pay 80% of what is reasonable and
26 necessary, and that may be less than what the doctor
27 charges, and the doctor says: "I am sorry, this is my
28 fee" and the patient is responsible, and the fact of
29 the matter is that the patient may be paying more than
30 80%.



1 MR. KILGOUR: That does happen, and
2 there have been classic cases where medical charges of
3 prominent or rich people are almost out of this world
4 and in those circumstances I don't think we can say they
5 are a reasonable and necessary fee.

6 THE CHAIRMAN: I think we will take
7 two or three minutes recess, gentlemen.

8
9 --- Short Recess

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11 COMMISSIONER FIRESTONE: Mr. Fitzhugh,
12 I understood you to say that in the case of your company
13 you are using those cancellation provisions or the right
14 to cancel a policy very sparingly, only in exceptional
15 circumstances?

16 MR. FITZHUGH: Just to be specific, sir,
17 we have no right to cancel. We have a right to refuse -
18 I am being technical - we have the right to refuse to
19 renew on the anniversary date. We don't have a straight
20 cancellation clause. In the States we have waived that
21 right by resolution of the Board.

22 In Canada they have already put in a
23 hospital plan, so we felt we had the right in order not
24 to have double coverage, but we have never used it to
25 refuse to renew solely because of deterioration in health.
26 We have done it for, as was mentioned, fraud, misrep-
27 sentation and things of that kind.

28 COMMISSIONER FIRESTONE: What is the
29 position in Great-West Life?

30 MR. KILGOUR: We have two forms of



1 policy. We have what is called commercial series where
2 we have a right not to renew, and that is if circumstances
3 change - we had to change all our policies at the time
4 hospitalization came in, and we also wrote a non-cancel-
5 lable form which guarantees it will always be renewed,
6 at a higher premium, and we have not cancelled or not
7 renewed them for deterioration of risk, and the circum-
8 stances we think are those very rare ones I referred to
9 earlier.

10 We have in the past not renewed policies
11 at specific ages. So we have told them when they take
12 out a policy it is renewable up to 65. I think we will
13 come to higher premiums for people after an age such as
14 65 and people in that group so we continue them. But
15 we have not done what is normally called cancellation.

16 COMMISSIONER FIRESTONE: Have you got
17 the right to cancel?

18 MR. KILGOUR: Yes.

19 COMMISSIONER FIRESTONE: You reserve
20 the right to cancel in all your policies?

21 MR. KILGOUR: Yes, except the non-
22 cancellable ones.

23 COMMISSIONER FIRESTONE: But in the
24 majority of your policies you reserve the right to
25 cancel?

26 MR. KILGOUR: Yes.

27 COMMISSIONER FIRESTONE: But you don't
28 cancel it because of deterioration of risk?

29 MR. KILGOUR: That is right.

30 COMMISSIONER FIRESTONE: In the case of



1 Metropolitan Life I understand you do not have the right
2 to cancel?

3 MR. FITZHUGH: That is right, but we
4 have the right to decline to renew.

5 COMMISSIONER FIRESTONE: To talk about
6 the right to decline to renew, when the hospital insurance
7 scheme came into operation did you rewrite your policies?

8 MR. FITZHUGH: Yes. Most of the
9 provinces required cancellation of existing hospital
10 insurance.

11 MR. BERRY: In the provinces where the
12 legislation prohibited the private insurers remaining
13 in the field we rewrote the contract by the addition of
14 a rider where it said these provisions were no longer
15 available because of the law, and there was a correspon-
16 ding adjustment of premium.

17 In the provinces where there was not a
18 prohibition against the private insurers we were able to
19 go along with these cases because we had a reimbursement
20 type of contract so we didn't have to pay over the top
21 of the other.

22 In the group field these contracts
23 were revised to take care of the medical situation.

24 MR. FITZHUGH: What has happened in most
25 cases - am I correct? - instead of just taking out the
26 hospital benefit and reducing the premium, we offered
27 coverage of some other type, nursing and so on.

28 MR. BERRY: In the group field parti-
29 cularly there was a great tendency to sort of leave the
30 premium alone and buy a broader package of benefits.



1 There was a great deal of this went on, and in the
2 individual field we made a different contract so that
3 people who didn't want to reduce the policy could buy
4 a broader contract with no hospital benefits in.

5 COMMISSIONER FIRESTONE: If I under-
6 stand you correctly, you have made the necessary adjust-
7 ments required as a result of the introduction of hospital
8 insurance legislation?

9 MR. BERRY: That is right.

10 COMMISSIONER FIRESTONE: And would you
11 therefore say that you could be in a position to apply
12 in Canada the same sort of practice you are now using in
13 the United States where you have given up the right to
14 refuse to renew?

15 MR. KILBOUR: I think you would be more
16 confident if the report of this Commission were read.

17 MR. BERRY: Would you mind repeating
18 the question, sir?

19 COMMISSIONER FIRESTONE: That is if
20 repeating it may I rephrase it differently? Mr. Fitzhugh,
21 did I understand you correctly in saying that you have
22 given up the right to refuse to renew in the United
23 States?

24 MR. FITZHUGH: That is right, sir.

25 COMMISSIONER FIRESTONE: What is preven-
26 ting you from applying the same principle to Canada today?

27 MR. FITZHUGH: The fact that we have
28 already learned that the Government has moved into the
29 hospital field and at least there is talk about an
30 extension, shall we say.



1 MR. KILGOUR: And in one province there
2 is legislation.

3 MR. FITZHUGH: That is right, in one
4 province there is legislation.

5 COMMISSIONER BALTZAN: You write policies
6 for people who want provision for private or semi-private
7 room over and above the basic?

8 MR. BERRY: Yes, sir.

9 COMMISSIONER FIRESTONE: May I now
10 deal a little further with this matter of cancellation,
11 the right not to renew. The way you have described the
12 practices of your two companies, it seems your two
13 companies are among the leaders in the field, you have
14 used your right very sparingly, in the long-term interest
15 of the population.

16 Would you say that the industry as a
17 whole follows this high principle, or would you say
18 there are companies who are not so high-principled as
19 these two companies?

20 MR. KILGOUR: There has been criticism
21 in the past that some companies have been severe in the
22 application of the cancellation privileges. I would say
23 that the majority of companies are adopting a wholly
24 broad, long-term view, completely consistent with the
25 policyholders' best interests.

26 In fact, there is quite a recent survey
27 about it I would like to be able to put my finger on,
28 data. I have it here if I can put my finger on the
29 right piece of paper. It is a study on cancellations
30 and the effect on 20,000,000 policies. Only .24% were



1 cancelled in a year out of 20,000,000. So statistically
2 it is a very thin minority. But there will be some
3 companies which are harsher, and I will admit that.

4 COMMISSIONER McCUTCHEON: You are not
5 ascribing your practice to high principle but to good
6 business?

7 MR. FIRESTONE: Both.

8 COMMISSIONER FIRESTONE: You said .04%?

9 MR. KILGOUR: .04%.

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1 COMMISSIONER FIRESTONE: You have pointed out
2 to us, and this is not on the basis of a survey, but
3 on the basis of judgment and experience, that there
4 are some companies, like your own, who are leaders
5 in the business, and are very careful, and keep the
6 long term interests of policy holders in mind, but
7 there are others who use those cancellation privileges
8 more freely or the right to refuse to renew. The
9 question arises whether it would be in the interest
10 of the health insurance industry to develop certain
11 minimum standards, so that anyone who buys a life
12 insurance policy would not get caught by some of
13 the companies using less forward-looking policies,
14 and a point I think we should bear in mind is that
15 these companies with those less adequate policies
16 are companies which give the industry as a whole a
17 black eye.

18 A question I would like to pose to you,
19 would you as a representative of two of the leading
20 companies be in favour of minimum standards of health
21 insurance for Canada?

22 MR. KILGOUR: I think on that I would express
23 the personal opinion that the provincial legislatures
24 have complete authority to stipulate what shall be
25 the standards, and that if in their judgment there
26 are some companies that are not measuring up to what
27 they regard as being in the public interest, that they
28 have the machinery to put greater teeth in the process,
29 and I think it would be entirely consistent in my
30 view that they should do it.



1 COMMISSIONER FIRESTONE: Would you not say
2 that a number of companies report to the Superintendent
3 of Insurance of the Federal Government?

4 MR. KILGOUR: Yes.

5 COMMISSIONER FIRESTONE: Would the same
6 principle apply to the federal Superintendent of
7 Insurance?

8 MR. KILGOUR: I stand to be corrected in
9 this, but it is my understanding that the federal
10 department is fundamentally connected with the solvency
11 of the companies, and the Federal Act is one designed
12 to set forth what a company may or may not do, the
13 powers of the board and regulate the company's
14 operations, but it is in the provincial orbit that
15 a policy provisions lie, and therefore it would be
16 provincial superintendents or legislatures who could
17 put in any provisions they deemed wise governing
18 the statutory provisions.

19 MR. BERRY: There may be a misunderstanding
20 here. A company cannot do business without being
21 licensed by the province in which it is doing business,
22 so that it is subject to their jurisdiction, even
23 though it is registered with the Dominion Department.

24 COMMISSIONER FIRESTONE: That is understood.

25 THE CHAIRMAN: You say it is understood. It
26 is just not the fact. A company which is going to
27 operate within the province, but there is nothing to
28 prevent a company in Mexico advertising a policy that
29 a Canadian can send to Mexico and buy a policy.

30 MR. BERRY: I think there again that there



1 is machinery by which that can be prevented, and I
2 think this case is somewhat outside the possibility
3 sir.

4 COMMISSIONER FIRESTONE: I think your
5 reference was Canadian companies, and the Chairman
6 raised the question, and quite rightly so, there are
7 companies operating from abroad which are not under
8 control. How does one deal with this sort of
9 practice?

10 MR. KILGOUR: I cannot express any opinion
11 on it, but I would think that there is extraordinarily
12 little business done in Canada by companies that are
13 not licensed by the province in which they are doing
14 business. There might be conceivably some bootleg,
15 mail order business, but I think it would be in the
16 most minute proportions, if it exists, and I think
17 between the federal and provincial departments there
18 are provisions which could outlaw that.

19 THE CHAIRMAN: How can you outlaw something
20 that is beyond the jurisdiction of your court?

21 COMMISSIONER FIRESTONE: Still coming back
22 to the basic point that there are companies whose
23 practice is not in the public interest, and we want
24 to find out whether you as senior representatives
25 of the industry have some concrete suggestions of
26 how we can come to grips with such a problem. You
27 have said that such control might be exercised by
28 provincial superintendents of insurance. As you realize,
29 this is a Royal Commission advising the federal
30 government, and therefore the sort of proposals that



1 we must consider are what can the federal government do
2 to help the industry to put its own house in order,
3 or perhaps we can rely on the industry to put its own
4 house in order?

5 MR. KILGOUR: Again I would rather shade
6 that statment that companies are doing things not in
7 the public interest, and say that they are doing
8 things that could be done better. One must have
9 regard to the premium rates on which they write the
10 policies, but certainly to the extent that there are
11 practices extant in Canada that are deemed to
12 be not in the public interest, to me the provincial
13 departments are the ones that have this responsibility,
14 that are deemed to be not in the public interest.
15 I think the insurance industry could collaborate
16 with them, and in fact we do meet periodically with
17 the superintendents, at which they discuss problems,
18 and if this is one in which enough people think they
19 should act, I think they could and should be encouraged
20 to put stronger measures behind practices that are
21 not deemed by the responsible authorities to be in
22 the public interest.

23 COMMISSIONER FIRESTONE: As for example,
24 the problem, or possibility of misleading advertising.
25 How does one handle this?

26 MR. KILGOUR: I think we have been relatively
27 free of it in Canada. It was an unhappy state in the
28 United States a few years ago, and there were steps
29 taken to do away with it.

30 COMMISSIONER FIRESTONE: What steps were taken?



1 MR. FITZHUGH: I have been silent, sir, as
2 a guest in your country. I felt it inappropriate for
3 me to suggest what you might do legislatively here,
4 but now you ask me what we did there, I feel free to
5 speak. Please understand that I am not saying that
6 this is what should be done in Canada. Conditions
7 are quite different. The whole philosophy of
8 supervision of insurance companies in Canada is
9 different than that in the United States. In Canada
10 the companies have been given more freedom, and in
11 general have lived up to those responsibilities
12 very well indeed. In the States, for whatever reason,
13 the laws and the supervisory authorities have had
14 much closer control. I will answer what has
15 happened in the States, without saying whether that
16 is appropriate in Canada.

17 Take the cancellation clause for example.
18 The National Association of Insurance Commissioners
19 took cognizance of this problem a few years back, and
20 the Health Insurance Association of America, which
21 corresponds to the Canadian Health Insurance
22 Association, cooperated fully, and recommended
23 something should be done. First they recommended
24 to their member companies to do it voluntarily but
25 then they and the Metropolitan in particular sponsored
26 legislation in the State of New York. This is a law
27 that was passed in New York State in 1958, which after
28 all the whereas's and so forth says:

29 "That after two years from
30 its date of issue"



1 and then we leave some more out,

2 "No insurer shall refuse to
3 renew a policy for medical health
4 insurance, or refuse to renew any
5 other policy of that nature,
6 except for one or more of the
7 following reasons, fraud in
8 applying for the policy or any
9 benefits under the policy, moral
10 hazard, over-insurance, or
11 duplication of the benefits,
12 according to standards on file
13 with the Superintendent of Insurance."

14 Then it goes on,

15 "After such two year period,
16 in no event shall any insurer
17 refuse to renew any such policy
18 because of a change in the physical
19 condition or health of the person
20 covered by the policy."

21 And it goes on further to say that you cannot beat
22 the devil around the bush by putting in restrictive
23 clauses.

24 On the subject of advertising, there are
25 specific requirements of the Federal Trade Commission,
26 the F.T.C. on the subject of fair advertising, and
27 they have issued a series of standards. The various
28 State Legislatures have done the same thing, to be
29 sure that insurers do not misrepresent their policies,
30 or overclaim for them, and just what you are talking



1 about. That has been, I would say, very successful
2 in reducing to whatever extent this problem existed
3 before. It is now illegal.

4 COMMISSIONER FIRESTONE: Thank you very
5 much for those comments. They are very helpful, but
6 if I may come back, Mr. Kilgour to the Canadian
7 situation, would you feel that the industry itself
8 could do something to establish minimum standards?

9 MR. KILGOUR: Here of course I can express
10 only a personal opinion, because there is a large
11 majority that I think are wholly unanimous, but
12 Associations do not have any police powers that I
13 have ever heard of, and if you are not able to get
14 everybody to enlist voluntarily, the last man on the
15 totem pole can make things rather unhappy for you if
16 he chooses to. To what extent it is, and I am
17 not aware that there are any such problems existing
18 in Canada today, although I was keenly aware of it
19 a few years ago, but you do not get a hundred per
20 cent batting average by asking people to do things
21 all the time.

22 COMMISSIONER FIRESTONE: Again expressing
23 personal opinions, since you said the industry itself
24 cannot perform these police functions, would you be
25 prepared, or would you support an industry proposal
26 to turn those police functions over to the federal
27 Superintendent of Insurance and I am saying specifically
28 the Federal Superintendent of Insurance, because I
29 am thinking in terms of establishing, the possibility
30 of establishing a national plan, not just for a



1 particular province.

2 THE CHAIRMAN: I am afraid Mr. Kilgour,
3 before answering, would have to consult his solicitors.

4 COMMISSIONER McCUTCHEON: The application
5 would be under the B.N.A. Act.

6 COMMISSIONER FIRESTONE: Without getting
7 involved in the legal question --

8 THE CHAIRMAN: I don't see how we can help
9 being involved when you put the question.

10 COMMISSIONER FIRESTONE: I am more interested
11 in examining the feasibility of what would be the
12 possibility of setting standards, and having an
13 effective police power to make sure that these
14 standards are maintained.

15 THE CHAIRMAN: Mr. Commissioner, the
16 legislatures of the ten provinces have full control
17 over the legislative field of insurance. They have
18 the power to enact whatever they may wish in that
19 regard.

20 MR. KILGOUR: We have a Uniform Act in
21 Canada.

22 THE CHAIRMAN: Yes, and then there is the
23 Uniformity Committee and the Uniform Act, which they
24 try to get all ten provinces to adopt, but not
25 completely ---

26 MR. BERRY: Well, nine provinces support the
27 Uniform Act, and the Province of Quebec is entirely
28 different and will start from a completely foundation.

29 COMMISSIONER FIRESTONE: Mr. Chairman, in
30 bowing to your vast knowledge of constitutional law --



1 THE CHAIRMAN: Just elementary knowledge now.

2 COMMISSIONER FIRESTONE: Knowledge is a
3 matter of degree. The problem before us is to see
4 what the Federal Government can do in this field.
5 The Commission is not advising provincial governments,
6 but the federal government. Can you see any way in
7 which the federal government can be of help to the
8 industry to establish such standards across the
9 country? I am referring now to insurance companies,
10 and other companies which report to the Federal
11 Superintendent of Insurance. As you know, there are
12 a number that do not. I am only concerned with those
13 that are under federal jurisdiction, and do report
14 to the Federal Superintendent of Insurance.

15 MR. KILGOUR: I think I am still in fairly
16 deep water and I am unfamiliar with any simple
17 technique by which the Federal Government can tell
18 the province what to do, but I don't think it is
19 even that complex. I will put it in another way. I
20 think that if some group is able to define an area
21 in which the public interest is not being well served
22 by the actions of insurers, that there is sufficient
23 provincial jurisdiction, and our provincial superintendents
24 and provincial legislatures have sufficiently keen
25 interest in the public welfare that if the position
26 was pointed up and with the majority of the industry
27 cooperating in finding a solution, that one can be
28 found on a provincial level.

29

30



/dpw

1 COMMISSIONER FIRESTONE: In principle,
2 you have no objection to increased control over standards
3 of performance?

4 MR. KILGOUR: By and large you like
5 as little legislation as you can have in life but to
6 the extent that our practice is not in a public interest,
7 none of us would resist that.

8 MR. BERRY: I was not sure what you
9 meant, I must confess I was a little behind you. You
10 said we would not object to control over standards of
11 performance?

12 COMMISSIONER FIRESTONE: Yes, based in
13 the sense of the discussion that has taken place previously
14 and the points that Mr. Kilgour had dealt with.

15 MR. BERRY: One thing about the discus-
16 sion that seemed to me, it gave an impression of some-
17 thing or things being rather seriously wrong without
18 them ever being defined. I do not know what it is we
19 are answering because I do not know what it is really
20 specifically that you have in your mind.

21 COMMISSIONER FIRESTONE: Well, we were
22 discussing, if you recall, the conversation that has
23 taken place, some expressions were discussed such as
24 undue use of cancellation privileges.

25 MR. BERRY: But nobody has said that
26 there is very much undue use of cancellation privileges.
27 We merely said there may be some companies whose practices
28 are different than our own.

29 MR. KILGOUR: At least we defined it in
30 one illustration as down to .04% so we are really talking



1 about a very, very slim range.

2 COMMISSIONER FIRESTONE: We accept the
3 figures as you gave them to us. We were discussing the
4 principle and not the degree.

5 If I may turn now to page 3, the second
6 paragraph, Mr. Kilgour; in the last sentence you say:

7 "The primary purpose of health insurance,
8 like that of other forms of insurance,
9 is to substitute the payment of a rela-
10 tively small regular premium for the
11 risk of large unpredictable losses,
12 in this particular case, heavy health
13 care costs".

14 What is your definition of "heavy"?

15 MR. KILGOUR: Well, using the first
16 illustration, heavy obviously varies with the individual.

17 COMMISSIONER FIRESTONE: Exactly, that
18 is why your answer will be very helpful.

19 MR. KILGOUR: If one is speaking of
20 employed persons we commonly recommend this process of
21 the \$25 deductible.

22 Now, I do not know how a \$25 annual
23 expenditure can be defined as other than a minor expense
24 for anybody living in Canada today. Anything that goes
25 wrong costs \$25; you can tear your trousers on the way
26 out of the room, \$25 is a moderate sum in any area of
27 bills you can think of and that covers 73% of an employee
28 group including retired people.

29 COMMISSIONER FIRESTONE: You really
30 answered my question very neatly by saying anything over



1 \$25 for the employed person you would consider a heavy
2 medical ---

3 MR. KILGOUR: No, I think anything
4 under \$25 is birdseed.

5 COMMISSIONER FIRESTONE: What would you
6 consider a heavy health care cost as stated in the
7 second sentence of paragraph 3?

8 MR. BERRY: I would like to take a try
9 at this one. Starting off by saying what is a heavy
10 health care cost for one man is obviously not a heavy
11 health care cost for another but it would seem to me
12 that a heavy health care cost would be one which is out
13 of proportion to the other kinds of obligations which
14 he is regularly prepared to enter into.

15 It is not necessarily a fixed sum of
16 money that he can put a finger on. What would be heavy
17 health care costs for you, Mr. Commissioner, might not
18 be heavy to somebody else or the other way around.

19 I think if you try to put it in perspec-
20 tive of the kind of obligation a man undertakes for his
21 family he may, for example, go out and buy an electric
22 refrigerator or an electric stove; he may think about it
23 and may have to get help with financing but he would not
24 think he was taking on something that would frighten him
25 out of his life.

26 I think that is the area we should be
27 talking about.

28 MR. KILGOUR: In fact, another that is
29 quite comparable is the automobile business. They do
30 not start under \$25 deductible and a great many people



1 have \$100 deductible. They repair their own fenders
2 and buy their new tires as they do in any other area
3 and in the health field it is a very minor expenditure.

4 COMMISSIONER FIRESTONE: You have been
5 very helpful in making general observations but I am
6 still not clear what you mean in this paragraph by heavy
7 health care costs. I understand that you insure primarily
8 heavy health care costs. If a man makes \$60 a week and
9 his health care cost is \$60 and he is married, would you
10 consider it is a heavy health care cost or not? It is
11 just two people and with \$50 deductible would bring this
12 in, is this a heavy health care cost or not?

13 THE CHAIRMAN: You mean at one time,
14 \$50 in a year?

15 COMMISSIONER FIRESTONE: We are talking
16 about \$50 deductible.

17 MR. BERRY: May I try to sort of
18 straighten out the sentence because I think you are
19 shifting the emphasis of the sentence. The sentence
20 says:

21 "The primary purpose is to cover heavy
22 health care costs"

23 and the point we are trying to make is that a man should
24 not use substantial portions of the money he has set
25 aside for premiums to pay for the little expenses which
26 he can pay cheaper out of his own pocket without any
27 burden on himself.

28 If you want to take an analogy without
29 trying to get a dollar figure, which I think is impossible,
30 the problem in automobile insurance is not the bent fender,



1 it is the chance of a public liability suit because you
2 have injured or killed somebody.

3 Now, this is the concept and in the
4 health care field I do not think you can say that \$25
5 or \$50 is a health care cost. Rather the prime purpose
6 of insurance is to be sure that it will be there for
7 the person who has a catastrophe.

8 COMMISSIONER FIRESTONE: I am trying to
9 find out what you meant by a catastrophe; is the purpose
10 of health insurance to cover only catastrophe?

11 MR. FITZHUGH: At the risk of repeating
12 I think that one of the critical advantages of a voluntary
13 health insurance scheme, I do not think I or Mr. Kilgour
14 or Mr. Berry or anybody else can say. What is heavy for
15 Mr. John Doe, the only fellow who can decide that is
16 Mr. John Doe.

17 The point we have in mind is that Mr.
18 John Doe should have the option, if he wants to cover
19 all his expenses and have no deductible he should be
20 able to provide himself with that kind of coverage; if
21 he wishes in fact to pay \$500 out of his pocket and says
22 he does not want to pay our overhead; wants a policy
23 with \$500 deductible, he should be able to have it.
24 He should be able to have a larger or smaller deductible
25 in larger or smaller brackets and he could define what
26 is a heavy health care cost for him a lot better than I
27 can.

28 COMMISSIONER FIRESTONE: Are you saying
29 that one should understand the concept of heavy health
30 care costs as being the relative concept in relation to



1 the income of the person concerned rather than an
2 absolute concept of the amount of expenditures involved;
3 is that what you are saying?

4 MR. FITZHUGH: Income and other factors.

5 COMMISSIONER FIRESTONE: I am trying to
6 understand what you mean, is that what you mean?

7 MR. FITZHUGH: Income and other factors
8 pertaining to the individuals.

9 COMMISSIONER FIRESTONE: All you have to
10 say is yes.

11 MR. FITZHUGH: I had to add "and other
12 factors".

13 COMMISSIONER FIRESTONE: What are the
14 other factors?

15 MR. FITZHUGH: The size of the family,
16 how much he has in the bank, what he desires, how much
17 importance he attaches to the good health of his family,
18 for instance, buy a new refrigerator; these are all
19 individual concepts and they are valuable to preserve
20 his right to make the decisions himself and not have us
21 make the decision for him because I do not think anybody
22 can.

23 MR. KILGOUR: I think I can illustrate
24 it another way that may be meaningful. Again, this is
25 illustrative of our own 5,000 people; last year, there
26 have been 100 of them that had really heavy health care
27 costs and some of those are claims under \$300.

28 They may have been heavy for the junior
29 stenographer, that still may have been a very heavy
30 item. Some of the larger claims, people with substantial



1 incomes, \$400 or \$500, may have not been seriously hurt
2 but they would have been heavy health costs for others.

3 I think one can say in this instance
4 it was not more than 2% of the group of 5,000 people and
5 it was not more than 100 or 2% of the group in a parti-
6 cular year that were hit by what an impartial observer
7 would say was a heavy health cost.

8 They have the feeling of enjoying the
9 mental satisfaction of knowing if they get hit by some-
10 thing that is heavy in relation to their circumstances
11 they are covered.

12 COMMISSIONER FIRESTONE: A simple
13 question: is the primary purpose of health insurance to
14 insure against the catastrophe or also amongst many
15 other types of illnesses that exist - the \$25 or \$50 or
16 \$75?

17 MR. KILGOUR: I think "heavy" is a
18 better word than "catastrophe". In other words, you
19 can say, for instance, the Federal Government has said
20 if your medical bills are more than 3% of your income
21 you get a deduction.

22 Now, maybe that is not a bad definition
23 of a heavy health cost in a year.

24 COMMISSIONER FIRESTONE: Thank you for
25 trying.

26 May I now turn to page 3, the fourth
27 paragraph, the first and second sentences and I quote:

28 "Inevitably there are going to be cases
29 (although perhaps not nearly so many
30 as some have suggested to you) where



1 the purse will be insufficient to
2 provide fully for a family's reasonable
3 needs. Traditionally this problem has
4 been met by the providers of medical
5 care - that is, the doctors - making
6 their services available either without
7 charge or on a reduced fee basis".

8 If I may deal with the second sentence
9 first, does this sentence mean that you gentlemen are
10 in favour of doctors continuing to subsidize medical
11 care of the indigent and the medically indigent or would
12 you feel that this should be a national responsibility?

13 MR. KILGOUR: I think we tried to avoid
14 taking any position on that because that is surely a
15 matter for the medical profession and not the insurers
16 to express an opinion.

17 In fact, I think we say what part should
18 be played by government and what part should be played
19 by the profession is not for us to say.

20 COMMISSIONER FIRESTONE: This may be
21 true; on the other hand, we are facing a problem in
22 connection with providing medical care services for the
23 indigent and the medically indigent and I gather that
24 you had some views that these should be taken care of?

25 MR. KILGOUR: Quite. In fact, on that
26 one, when I was appearing with the Chamber of Commerce
27 in Winnipeg, we put that hat on and I assure you that
28 we won't quarrel on that one. There is a field for the
29 government to co-operate with the medical profession in
30 setting up a plan for these people who cannot provide



1 for themselves. We are doing that in every other field
2 of activity, clothing, food, housing, and clearly those
3 people who are in need of medical care, I see no objection
4 to doctors being paid to look after these people. That
5 is something that the State should do for these people.
6 That is sort of a personal opinion.

7 COMMISSIONER FIRESTONE: Obviously
8 you are expressing personal views on these subject
9 matters. If I understand you correctly, and please
10 correct me if I do not; your own personal views would
11 be it would be more appropriate for society as a whole
12 to pay the medical care bills of these people than
13 having doctors pay it out of their own pockets, the
14 pocket in the sense that provides service without pay-
15 ment or on a reduced fee basis: is that your view?

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1 MR. KILGOUR: Quite sir.

2 COMMISSIONER FIRESTONE: Thank you for the
3 comments. Now may I turn to the first sentence which
4 says in the bracket:

5 "Although perhaps not nearly
6 so many as some have suggested to
7 you".

8 Now this brings us to the question of who are the
9 people in need of medical care who cannot afford to
10 pay for it? I am just wondering whether from your
11 experience you can tell us what kind of people are
12 policy holders in terms of say weekly income. Have
13 you for example policy holders that acquire your
14 standard type of policies with incomes of \$60.00 or
15 more a week or \$70.00 or more? Have you got policy
16 holders with \$50.00 a week? I am not looking for an
17 exact figure but what would be a minimum income that
18 would make it difficult for people to acquire a
19 coverage under an individual contract assuming that
20 you are talking about a married couple?

21 MR. KILGOUR: I querie whether one can
22 define a minimum income when you realize that in --
23 again I come back to Manitoba, when you realize that
24 in Manitoba an individual can buy complete medical
25 service for \$25.00 or \$30.00 a year. I don't know who it
26 is that is not truly indigent cannot afford \$25.00
27 or \$30.00 a year.

28 THE CHAIRMAN: Are you sure of that figure,
29 Mr. Kilgour?

30 MR. KILGOUR: Individual rates? Yes. Put



1 it another way, and I know that regardless of age
2 you can get in -- I know this 79 year old lady who
3 recently joined the plan and her premium was only
4 \$42.00 a year so that if they are not applying it to
5 individuals who are of younger ages for \$25.00 a year,
6 there must be something wrong with them.

7 COMMISSIONER FIRESTONE: Let me put it this
8 way: from your experience would there be many policy
9 holders earning \$50.00 or less in your company?
10 \$50.00 or less a week?

11 MR. KILGOUR: We cover a million and a half
12 Canadians, the two companies, so I expect we cover
13 the whole range of employable-employer groups and
14 we think many people probably do go down well below
15 \$50.00 a week under group plans. Individual plans --

16 COMMISSIONER FIRESTONE: I am talking about
17 individual plans.

18 MR. KILGOUR: Individual plans, again it
19 probably varies very much for the individual.

20 COMMISSIONER FIRESTONE: But you would say
21 the majority would be --

22 MR. KILGOUR: More than that.

23 COMMISSIONER FIRESTONE: The majority would
24 be -- 90 per cent or more more than \$50.00 a week?

25 MR. KILGOUR: This is very hard to say.

26 MR. BERRY: I was just going to say that
27 low incomes tend to be uncertain and they will not
28 take on continuing obligations but I would say we
29 insure with some frequency down to \$50.00 a week.

30 COMMISSIONER FIRESTONE: But you would be



1 careful on a policy for somebody less than \$50.00?

2 MR. BERRY: They don't come to us.

3 COMMISSIONER FIRESTONE: This gives us just
4 a bench mark, and we need this bench mark in order
5 to understand what you mean "although perhaps not
6 nearly so many as some have suggested to you." I have
7 looked at the publications published by the Department
8 of National Revenue Taxation Statistics 1961 which
9 show that for the year 1959 there were 4.2 million
10 taxpayers out of a total of persons in the labour
11 force of 6.2 million. In other words, there were
12 two million people in the labour force, most of them
13 working, some unemployed who were not subject to
14 income tax payments. Presumably their income has
15 been so low that they were not required to pay
16 income tax however there are therefore two million
17 income recipients or two million classified as persons
18 working whose income is too low to be covered by
19 income tax.

20 Now, furthermore, there were something like
21 ten per cent of the persons paying income tax with
22 incomes below \$2400.00, which is \$50.00 a week so if
23 you add the two million people and the 400,000
24 together you have 2.4 million working people that
25 have incomes which would make it difficult for them
26 to acquire an insurance policy under the existing
27 scheme.

28 Now these are -- I am just bringing the
29 facts to you. If you have some comments, I would
30 appreciate it greatly if you can give us some further



1 elaboration.

2 MR. FITZHUGH: Yes. This is just a question
3 of fact. I am trying to keep out of economic
4 discussions in Canada but let's take your figure of 2.4
5 million employees who are making less than \$50.00 a
6 week.

7 THE CHAIRMAN: Who are not paying income tax.

8 MR. FITZHUGH: What was the 400,000?

9 COMMISSIONER FIRESTONE: Let me go slowly and
10 say there were 6.2 million people in the Canadian labour
11 force in 1959. 4.2 million were paying income tax.
12 Therefore, there were two million people that were
13 not paying income tax because apparently the income
14 was too low to fall within the income tax provisions.
15 Now in addition to it there were 400,000 persons
16 paying income tax on an income of \$2400.00 per year
17 or less than \$50.00 a week.

18 MR. FITZHUGH: I thought that is what I said.
19 Apparently I didn't. Taking those figures you then
20 say there are that many people who would find it
21 difficult to have voluntary insurance?

22 COMMISSIONER FIRESTONE: I am not saying
23 this. I am asking a question sir --

24 MR. FITZHUGH: My answer is no.

25 COMMISSIONER FIRESTONE: That is why we
26 are coming to you for advice.

27 MR. FITZHUGH: My answer is that there are
28 not that many people first because the vast majority
29 of those people are working for an employer who will
30 pay all or part of the premiums for them. Most of



1 those people will be eligible for group insurance on
2 a voluntary basis which reduces that 2.4 million
3 very very materially and the other observation is
4 in general that those whose incomes were too small
5 to pay income tax, a lot of them do not have a cash
6 income to pay income tax -- I am getting out of my
7 field now. I should leave this to the Canadians.

8 MR. KILGOUR: I was going to say I think
9 the income tax figures published only show the
10 difficulty of approaching some of these figures on a
11 totally realistic basis. Certainly in the rural
12 population, in the northern population, many parts
13 of Canada there are people whose cash incomes are
14 not taxable but who have their living provided and
15 they own their own houses and in many respects they
16 have a greater margin in cash than many an industrial
17 worker who has his whole pay going out in commitments
18 every month, so that I do not think there are many
19 of them -- where there are two brothers living
20 together, one on a mink ranch and one doing something
21 else and their income together makes them thoroughly
22 solvent and solid. Therefore, the rural parts of
23 the country I don't think one can deduce from income
24 tax figures these people do not have a margin in the
25 order of \$40.00 or \$50.00 or \$60.00 a year to pay
26 for health care if they want it. Many of them take
27 this as just another hazard of life and are quite
28 happy with it.

29 MR. BERRY: May I make two points? The
30 400,000 people who are in the bottom class of income



1 tax, you undoubtedly have a very large number of
2 young single people. These are people who are just
3 starting to work. I think at the other end of the
4 scale you have now and will have in increasing numbers
5 people who have gone from the labour force but who
6 are still covered under the group plan of their
7 employer as a retired employee so that there are a
8 great many things that I think have to be taken into
9 account which you cannot disregard if you want to
10 make a simple arithmetical calculation from those
11 figures.

12 COMMISSIONER FIRESTONE: Of course nothing
13 is simple when it comes to statistics and we have
14 a very competent research staff to look at the
15 question further. All I want to know from you is
16 how you felt about this phrase "although perhaps not
17 nearly so many as some have suggested to you", when
18 you look at some of the evidence and I quite agree
19 gentlemen that the evidence is not conclusive.
20 Requires more research to establish what the true
21 facts are. On the surface one must say there are
22 many many people that would find it difficult to
23 afford the premiums. That is why we talk of the
24 indigent and medically indigent, the latter being
25 not people that are on welfare but people for one
26 reason or another find it difficult to pay. I
27 think you have said enough. I am very much obliged
28 to you for these comments.

29 May I turn now to another question. The
30 Chamber of Commerce when they were here earlier this



1 week suggested in quoting figures of the Department
2 of Health and Welfare that 48 per cent of the people
3 of Canada were covered by voluntary plans, with
4 medical coverage and they said eleven per cent were
5 covered with comprehensive coverage.

6 Now Mr. Kilgour you have made a very
7 convincing case about the great benefits derived from
8 this comprehensive coverage policy, which, incidentally
9 we understand are increasing in numbers very rapidly
10 in the last two years. The question I would like
11 to ask you is this: Do you think that we can
12 achieve under a voluntary system of health insurance
13 something like 75 to 85 per cent coverage remembering
14 that we have on the comprehensive only 11 per cent
15 and I take it this is the kind of coverage you would
16 like to see most Canadians obtain if we want to
17 provide adequate health service.

18 MR. KILGOUR: I wouldn't detract from the
19 service plans who are covering very large groups.

20 COMMISSIONER FIRESTONE: Or the service plans.

21 MR. KILGOUR: It is my personal philosophy
22 these comprehensive plans are very valuable to more
23 people.

24 COMMISSIONER FIRESTONE: It's a combination
25 of these two.

26 MR. KILGOUR: I would think when you have regard
27 to the growth of private plans in the last decade that
28 a figure of the order of 70 per cent is by no means
29 unrealistic.

30 COMMISSIONER FIRESTONE: You are referring



1 now to a combination of comprehensive and service
2 plans?

3 MR. KILGOUR: Right.

4 COMMISSIONER FIRESTONE: Not just ---

5 MR. KILGOUR: No, the total of the two plans.
6 The growth in the last ten years -- I wish I could
7 quickly put my fingers on it.

8 MR. BERRY: Which figures are you looking for?

9 MR. KILGOUR: The premiums of the licensed
10 insurers have virtually doubled in the last ten years.
11 No, they multiply by four in the last ten years and
12 if that rate of progress is kept up for about another
13 five years, and the service plans are equally
14 expanding I think one would be very close to the 70
15 per cent.

16 COMMISSIONER FIRESTONE: In other words, you
17 would expect that, without making just a statistical
18 statement, if the plans were -- if the rate
19 continues. This we accept, but what is your own
20 judgment and this question is very basic to this
21 Commission: If you are saying that voluntary plans
22 provide such adequate service, and assuming that
23 there is a demand in Canada for a more adequate
24 coverage of medical care service, the question that
25 I can put to you is: what are the prospects of
26 achieving 75 to 85 per cent coverage under the
27 present system or any means that you may think of?

28 This is really the test of the present
29 system. Can we provide adequate coverage across
30 the country to a large number of people because if



1 this were possible it would be an answer to those
2 who say well we can't, the present system does not
3 assure us of this objective and since we want
4 comprehensive or National coverage, we ought to have
5 a state plan.

6 COMMISSIONER McCUTCHEON: Would it be
7 fair to ask Mr. Kilgour, if it can be made available
8 to that number of people it would be for the
9 individual, surely, to decide whether he would take
10 it.

11 MR. KILGOUR: That was the point that was
12 puzzling me.

13 THE CHAIRMAN: You would have to accept it
14 is available now.

15 MR. KILGOUR: It is available but many --
16 perhaps one has to say in some areas it is not readily
17 enough available. I would have to say that in many
18 of the rural parts of Canada that health insurance
19 is not readily enough available; that it is not intriguing
20 or sufficiently convenient to buy for a fair number
21 of people to overcome a certain amount of inertia
22 perhaps to do it.



W 1 But with these imponderables of how
2 many people won't do it, we follow every prudent course,
3 which is a thing of part of living, lots of people take
4 any number of hazards and just not do this and do that.

5 I would say that 70% is not an unobtain-
6 able figure within a short time.

7 COMMISSIONER FIRESTONE: A short time
8 being what? Four years?

9 MR. KILGOUR: 75% of the people in
10 British Columbia are not covered. If these many
11 expressions of desire in signing up for a plan, if it
12 is truly the wish of the Canadian people to buy health
13 insurance, then we can hit 70% very fast.

14 COMMISSIONER FIRESTONE: You said you
15 won't achieve this without quite a substantial sales
16 effort?

17 MR. KILGOUR: Quite.

18 COMMISSIONER FIRESTONE: Given the
19 sales effort that you and other companies are making
20 and given the chances of policies and given improvements,
21 would you say that it would be hoped to achieve a target
22 of 75% or 80% in five years?

23 If you feel you want to think about it
24 and let us know at some future date, fine. I don't want
25 you to commit yourself to anything, but we want some
26 guidance as to what we could expect the industry to do
27 if it was left to its own devices. I am sure it is a
28 reasonable question.

29 MR. KILGOUR: I would be very disappointed
30 if we didn't have 75% of the people covered in five years.



1 COMMISSIONER FIRESTONE: Thank you.

2 That is a very straightforward answer.

3 MR. BERRY: The 75% to 85% which you
4 use, is this the total population of Canada or are we
5 talking about 75% to 85% of the people after you deduct
6 the Eskimos, the Indians, and so forth, who are govern-
7 ment wards? 75% of what, if I may ask?

8 COMMISSIONER FIRESTONE: Of the total
9 population of Canada. The pressures that have come
10 forward are for a national plan.

11 MR. BERRY: I think your question, if
12 I may be so bold, is not fair. If you take 75% to 85%
13 of the population without known population statistics
14 you might be talking of 95% of the people who could
15 conceivably be available.

16 COMMISSIONER FIRESTONE: Of course,
17 without trying to return a compliment of fair or unfair
18 to you, there is also the question of the medically
19 indigents, and we have been discussing with Mr. Kilgour
20 - he made the point very clear - that proposals are
21 under consideration about how you could extend the
22 coverage to the many other groups that are not covered,
23 which would include the aged, people with pre-existing
24 condition and certain groups which can go into it,
25 people who may lose their jobs and be unemployed.

26 Now, I give full credit to the industry.
27 I am satisfied with the answer I have from Mr. Kilgour,
28 and I would like to thank Mr. Kilgour and you gentlemen
29 for your very helpful presentation.

30 THE CHAIRMAN: Mr. Kilgour, there is



1 just a question that has been turning over in my mind.
2 You represent a stock company which in its broader
3 aspect will be looking to pay dividends to its stock
4 shareholders. Mr. Fitzhugh represents a mutual company.
5 In the future that Dr. Firestone has been talking about,
6 how does the stock company compete with a company that
7 has not to pay dividends to its stockholders?

8 MR.KILGOUR: If I could speak to that,
9 the answer is thus far we haven't paid any dividends to
10 stockholders. Well, it is not quite that bad.

11 THE CHAIRMAN: It is still a pious
12 hope.

13 MR. KILGOUR: We have now been in the
14 business since 1942 and we have as yet not taken one
15 nickel out of our account, and it was maybe two years
16 ago the Superintendent was breathing down our necks
17 that we have sufficiently adequate reserves, and last
18 year we had 1.9% of our premium income left over, all
19 of which we added to the reserve against the contingencies
20 which may evolve in another year.

21 In the previous year we had .9%; in
22 other words, we paid out 99.1% of our premiums. If we
23 are trading in a range of .9% and 1.9%, and obviously
24 one year could wipe that out, that is about as close a
25 definition of not for profit as one could find - equally
26 not for loss.

27 We went into this business because we
28 believed it was a public service that had to be supplied
29 and we were the people who could do it, and we can only
30 compete with mutual companies with service plans by



1 offering what the public wants and what they can pay so
2 that there may be sufficient left over at the end of
3 the year, and if that can happen over ten years in a
4 row conceivably we will make some money out of it.

5 We have not taken any money out of our
6 account for stockholders, and it was only two years
7 ago that the Superintendent was concerned about it and
8 we all had to put in reports that we were not having
9 losses in this field.

10 THE CHAIRMAN: So we don't need to go
11 home with the idea that the stock companies are putting
12 away great chunks of money in this health insurance
13 field.

14 MR. KILGOUR: I can certainly say that
15 of our company in this field. We have to compete with
16 them all, and it will be interesting.

17 MR. FITZHUGH: It may sound a little
18 odd for a representative of a mutual company to stand
19 up for a stock company, but the Great-West and the other
20 companies are tough competitors, so to that extent I am
21 supporting his statement that the fact that they are a
22 stock company they can still provide insurance to the
23 public at the same cost as a mutual company.

24 They would have to or they would be
25 out of business. I wish they were not that good.

26 THE CHAIRMAN: Thank you, gentlemen.
27 It has been extremely interesting and profitable.

28 MR. FITZHUGH: Thank you very much. It
29 has been our pleasure to be here, sir.



1 MR. HALL: The next submission is by
2 The Medical Council of Canada. May this brief be filed
3 as Exhibit No. 201?

4
5 --- EXHIBIT NO. 201: Submission of The Medical Council
6 of Canada.

7
8 MR. HALL: The brief will be presented
9 by Dr. A.L. Richard.

10 SUBMISSION OF THE MEDICAL COUNCIL
11 OF CANADA

12 Appearances: Dr. A.L. Richard
13 Dr. H.M. Stephen

14 DR. RICHARD: Mr. Chairman, members of
15 the Commission, I have the honour in the name of the
16 Medical Council of Canada to present this brief, which
17 is really brief.

18 The history of the Medical Council can
19 be summarized as follows:

20 1. The responsibility of ensuring that
21 practitioners of medicine are competent, and of main-
22 taining the highest standards of medical education, has
23 always been of great concern to the medical profession.
24 In spite of the occasional misrepresentation of its
25 motives and actions, organized medicine can point to a
26 long and proud history of continued efforts to develop
27 methods by which the public can be assured of competence
28 in those who serve their medical needs. Legislative
29 schemes to that end have been devised from historic times,
30 but the greatest advances have occurred within the last
century.



1 2. In Canada at the time of Confedera-
2 tion the situation was chaotic. Each province had its
3 own system of assessing applicants and of granting
4 registration and the right to practise medicine. The
5 result was that standards of education and practice
6 varied widely and the qualifications of a medical man
7 were not recognized beyond the borders of a particular
8 province. Haphazard efforts were made at reciprocal
9 arrangements but this proved unsuccessful in eliminating
10 a confusion that was a serious menace to the public good.

11 3. In 1867 the new-born Canadian
12 Medical Association attempted as one of its first
13 objectives to establish standards that would be accepted
14 on a national basis. These efforts met with the usual
15 difficulties that are inherent in our national complexion
16 and the struggle to surmount them was long and hard.
17 The story is concisely set forth by Dr. H.E. McDermot in
18 his biography of Sir Thomas Roddick - the man who, above
19 all others, was responsible for eventual success. By
20 his courage, diplomacy and perseverance he led the way
21 to a final agreement which is embodied in the Canada
22 Medical Act. This Act came in force in 1912 and the
23 medical profession can take pride in the fact that, a
24 half century ago, they succeeded in establishing a truly
25 national approach to questions of determining professional
26 competence and the granting of licensure - a step far in
27 advance of sister professions in Canada.

28 PURPOSE OF THE MEDICAL COUNCIL OF CANADA

29 4. The purpose of the Medical Council
30 of Canada is to conduct examinations of such a character



1 that high professional standards shall be maintained
2 throughout Canada. These examinations must be acceptable
3 to all the Provinces and they must not be lower than the
4 highest standard established in any province for the
5 like purpose.

6 5. It remains within the domain of
7 each Provincial Medical Council to determine:

8 (1) The qualifications or conditions
9 required preliminary to the study of
10 medicine.

11 (2) The qualifications or conditions
12 required to obtain a licence to practise
13 in each particular province.

14 6. All the Provinces in Canada have
15 accepted the examinations of the Medical Council of
16 Canada as one of the requirements to the granting of a
17 provincial licence.

18 COMPOSITION OF COUNCIL

19 7. The composition of the Council
20 brings together representatives of the Federal Government,
21 medical educators and practitioners. It is composed of

22 (a) three members appointed by the
23 Governor General in Council;

24 (b) two members representing each
25 province, who shall be elected under
26 regulations to be made in that behalf
27 by the provincial medical council;

28 (c) one member from each University
29 or Incorporated Medical School or
30 College in Canada having an arrangement



1 with a University for the conferring
2 of degrees on its graduates;
3 (d) three members who shall be elected
4 by the homeopathic practitioners in
5 Canada, each of whom shall reside in
6 a different province.

7 ELIGIBILITY FOR COUNCIL EXAMINATIONS

8 8. To be eligible for any examination
9 prescribed by the Council the candidate must

- 10 (1) possess a provincial licence, or
11 (2) present a certificate from his
12 own provincial medical council that
13 he holds a medical degree accepted
14 and approved of by that provincial
15 medical council.

16 SUMMARY AND RECOMMENDATIONS

17 9. The Medical Council of Canada was
18 evolved to meet the need for a national licensing body
19 acceptable to all Provinces. We believe that this need
20 is being met and any problems that arise stem from the
21 nature of Canada's political constitution.

22 10. Since the Medical Council of Canada
23 is performing a useful task it should be maintained, and
24 any measures leading to better educational standards
25 should be encouraged.

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1 Thank you gentlemen.

2 THE CHAIRMAN: Thank you very much Dr.

3 Richard. Have you anything to add Dr. Stevens?

4 DR. RICHARD: No sir, I think that we tried
5 to make a brief, to keep it brief, and the object
6 of the Council that we ask to be maintained is
7 contained in the last six lines.

8 COMMISSIONER McCUTCHEON: We have had no
9 recommendations that the Medical Council of Canada
10 be done away with so far.

11 DR. RICHARD: We would hope that it will stay.

12 THE CHAIRMAN: Does it apply to all ten
13 provinces, or is there a limitation on the acceptance
14 of your examination by one or more?

15 DR. RICHARD: All provinces, including the
16 last province, have accepted the agreement of the
17 Medical Council. We are only concerned with
18 examinations. We are not concerned with problems of
19 education in itself, although we are interested in
20 education. We are concerned by having a system of
21 examinations that would be the same for all
22 candidates throughout Canada.

23 THE CHAIRMAN: This enables considerable
24 mobility then within Canada?

25 DR. RICHARD: It surely does, on conditions
26 that the candidate satisfies other requirements, which
27 change from one province to another province.
28 Sometimes it is a bit like the reunion of provincial
29 Premiers.

30 COMMISSIONER BALTZAN: I am going to ask



1 you a question that I should really know the answer
2 to, but I don't. Certain provinces have
3 reciprocity with the U.K., and automatically a
4 candidate then becomes licensed in the province. Once
5 he is licensed in that province, does he automatically
6 get the licentiate of the Council of Canada or not?

7 DR. RICHARD: No, he must first of all
8 bring to the College of Physicians and Surgeons
9 what we call an enabling certificate, and since 1954
10 it requires also that the candidate must have one
11 year of internship.

12 DR. STEVENS: He has to have done a year's
13 internship to become registered, but not to try the
14 examination. He may try the examination before the
15 internship.

16 COMMISSIONER VAN WART: Under No. 6, you
17 state that all the provinces in Canada have accepted
18 the examination of the Medical Council of Canada
19 as one of the requirements to the granting of a
20 provincial license. That means that some provinces
21 reserve the right to not accept a candidate who
22 hasn't passed your examination for one reason or
23 another?

24 DR. RICHARD: Quit right Dr. Van Wart but
25 not on the examination, on other conditions, such
26 as citizenship in some provinces.

27 COMMISSIONER VAN WART: We had an incident
28 in British Columbia of one candidate who refused to
29 take a basic examination in that province, that is
30 on basic subjects of medicine, and was refused a



1 license by the province.

2 DR. RICHARD: This was not in the domain
3 of the Medical Council of Canada. It was a provincial
4 right that was applied.

5 COMMISSIONER VAN WART: Your examinations
6 do not cover the basic subjects per se. You have
7 eliminated them now, anatomy and so on?

8 DR. RICHARD: Yes, we have eliminated them.
9 We have general medicine, surgery, obstetrics,
10 gynaecology, public health and paediatrics.

11 COMMISSIONER VAN WART: Most of the provinces
12 accept the university degree as to the candidate being
13 proficient in the basic sciences?

14 DR. RICHARD: Yes, and many universities
15 at the present time accept as their final examination
16 the examination set up by the Medical Council of
17 Canada.

18 COMMISSIONER VAN WART: I realize that, yes,
19 but the province still can set an educational
20 examination on the basic sciences if they wish?

21 DR. RICHARD: That is right.

22 THE CHAIRMAN: Thank you very much gentlemen.

23 We will rise until 10:00 o'clock tomorrow
24 morning.

25 ---Adjourned.

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